CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. Establish retention period for records which are accumulating daily.	B. Dispose of present accumulation, no additional accumulation anticipated.	C. Microfilm and destroy originals.	D. Microfilm and retain originals for length of time indicated below.
☐	☐	☐	☒

9. Recommended Retention Period			10. Equipment and space freed	11. In your opinion does this record have any historical significance?
a. In Dept.	b. In Storage Center	c. Total		YES ☐ NO ☒
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber, M.D. Title: Commissioner of Health — 3/18/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept.	b. In Storage Center	c. Total	A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	☒	☐

REMARKS: 2 negative Rolls

C. P. Force — Records Management Officer — 3/18/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR — Howard C. Byrnes
2. APPROVED: CITY SOLICITOR — Thomas B. Bouse
3. APPROVED: CITY COMPTROLLER — Hyman A. Pressman
4. APPROVED: CITY TREASURER — John E. [illegible]
5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS — Bernard Turnbull
6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM — W. T. Hunter, Carl N. Hunter
7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21051

CERTIFICATE OF DEATH.

90

E 21051

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Brookfield ST. 13-54 WARD)

2-FULL NAME Rohlie Harris Berman.

(a) RESIDENCE No. 2012 Brookfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kunda M. Berman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 83 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rohlie 018

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Feinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levis (Address) 1439 E Baltimore St

15 Filed APR 10 1927, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from January, 1925, to April 8th, 1927, that I last saw h[illegible] alive on April 8th, 1927, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Hypertension

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Abrahams, M. D.

4/9, 1927 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herrun Run — DATE OF BURIAL: 4/10 1927

20 UNDERTAKER: Jack Levis 1439 E Balto — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21052

CERTIFICATE OF DEATH.

15-001

14 E 21052

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 5-21 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Page

(a) Residence No. 1816 N. Mount St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, ~~HUSBAND of~~ (or) WIFE of Dr. Geo. C. Page.

6-DATE OF BIRTH (month, day and year) March 24, 1895

7-AGE. 32 yrs. ..... mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) Washington (State or Country), D. C.

PARENTS.

10-NAME OF FATHER Abraham L. Jones

11-BIRTHPLACE OF FATHER (city or town) Washington (State or Country),

12-MAIDEN NAME OF MOTHER Maggie B. Saunders

13-BIRTHPLACE OF MOTHER (city or town) Washington (State or Country), D. C.

11- (Informant) Dr. Geo. C. Page

(Address) 1816 N. Mount St.

15-

Filed Apr 10 1927 CHAMPION JONES, M.D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9 '27

17- I HEREBY CERTIFY, That I attended deceased from March 28 1927 to April 9 1927

That I last saw him alive on April 9 1927

and that death occurred, on the date stated above, at 7-00 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcic Septicemia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cesarian Section

(Duration) ..... yrs. ..... mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 28 27

Was there an autopsy? Not.

What test confirmed diagnosis? Blood Cultures.

(Signed) Margaret B. Ballard, M.D.

, 19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19 27

UNDERTAKER ..... ADDRESS .....

Clarence E. Wright Lake Roland

instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 21053 — REGISTERED NO. E 21053

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Williams

(a) RESIDENCE NO. 1130 Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred over 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jannie Williams

6 DATE OF BIRTH (month, day, and year) April 1st 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer General

9 BIRTHPLACE (city or town) North Carolina

(State or country)

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (City or town) North Carolina

(State or country)

12 MAIDEN NAME OF MOTHER Lucy Downs

13 BIRTHPLACE OF MOTHER (city or town) North Carolina

(State or country)

14 Informant Eddie Upshaw

(Address) 1702 Washington Ave

15 Filed APR 10 1927 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7 1927 to April 8 1927

that I last saw him alive on April 8 1927

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Frank Lamunde Jr. M. D.

. 19 (Address) Prov. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion — Date of Burial April 11 1927

20 UNDERTAKER Samuel E. Wright — ADDRESS 1364 Argyle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

2444 Eutaw Pl. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21054

CERTIFICATE OF DEATH

90

REGISTERED NO. E 21054

1-PLACE OF DEATH

City of BALTIMORE: (No. 2512 Brookfield Ave. St.) (13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Wohlmuth

(a) RESIDENCE NO. 2512 Brookfield Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. if of foreign birth 27 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE — Years: 74 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Austria

(State or country)

PARENTS

10 NAME OF FATHER: Pinkes Bloldy

11 BIRTHPLACE OF FATHER (City or town): Austria

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah

13 BIRTHPLACE OF MOTHER (city or town): Austria

(State or country)

14 Informant: Mrs. Laura Wohlmuth

(Address) 2512 Brookfield ave

15 Filed ... 19... CHARLES J. JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15 1927 to April 8 1927

that I last saw her alive on April 8 1927

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Arteriosclerotic)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Ascending Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman M. D.

April 19 27 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cemt Date of Burial 4/10 1927

20 UNDERTAKER: Sol Levinson & Bro ADDRESS 1127 E Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 10 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21055

CERTIFICATE OF DEATH.

57 E 21055

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 E North Ave St. 12-14 Ward)

2-FULL NAME Susie Carroll McConkey

(a) RESIDENCE NO. 427 E. North ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James D. McConkey

6 DATE OF BIRTH (month, day, and year): April 26 1861

7 AGE — Years: 65 | Months: 11 | Days: 13 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert B. Carroll

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Nolan

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Frederick Miller

(Address): 427 E. North ave

APR 10 1927

Registrar: HAMILTON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1925, to April 9 1927, that I last saw h[illegible] alive on April 8 1927, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Diabetis mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of left foot

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lewis M. D.

4/10, 1927 (Address) 4 E. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: April 11 1927

20 UNDERTAKER: Chas. S. Black — ADDRESS: 742 W. North ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 21056

CERTIFICATE OF DEATH.

E 21056

REGISTERED NO. E 21056

1-PLACE OF DEATH General German Aged Home

City of BALTIMORE: (N. Baltimore and Payson St. 10-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherina Houff

(a) RESIDENCE NO. Baltimore & Payson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Henry Houff

6 DATE OF BIRTH (month, day, and year) Nov. 4-1838

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	88	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kur Hessen

(State or country) Germany

PARENTS

10 NAME OF FATHER Christof Bergman

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Elizabeth Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records German Aged Home

(Address) Baltimore & Payson Sts

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1927

17

I HEREBY CERTIFY, That I attended deceased from April 8th, 1927, to April 9th, 1927, that I last saw h-ee alive on April 8th, 1927, and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Houff, M. D.

4-9-1927 (Address) 1843 W. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial April 11 1927

20 UNDERTAKER Jas B Cook ADDRESS 503 W Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 21057

E 21057

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 Auchentoroly Terrace St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ollie S. Sloatfield

(a) RESIDENCE NO. 2900 Auchentoroly Terrace Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Sloatfield

6 DATE OF BIRTH (month, day, and year) September, 8th. 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	49	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) Prince Frederick

(State or country) Md

PARENTS

10 NAME OF FATHER Silas King

11 BIRTHPLACE OF FATHER (City or town) Prince Frederick

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) PrinceFrederick

(State or country) Md.

14 Informant George H. Sloatfield

(Address) 2900 Auchentoroly Terrace

15 Filed APR 10 1927 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 9th. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 9 1927

that I last saw her alive on April 8 1927

and that death occurred, on the date stated above, at 1.25 A. m.

The CAUSE OF DEATH* was as follows: Carcinoma of breast.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of July 22 July 20

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Irvin Eshaugh M. D.

4/9 1927 (Address) 700 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Apr 11" 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Balto St.

IMPORTANT—Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 21058

REGISTERED NO.

E 21058
1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp St. 25-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Denord Bates

(a) RESIDENCE NO. Balto City Hospital Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

16 Herbert St

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 64 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O&W

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Interment Geo. E. Fenton

(Address) 1916 Herbert st

Filed ..... 1927 C. HAMILTON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-15 1927 to April. 9, 1927

that I last saw him alive on April. 9, 1927

and that death occurred, on the date stated above, at 6.58 P m.

The CAUSE OF DEATH* was as follows:

Fracture R.F. Femur (over) Osteosarcoma Chronic Nephritis (Unknown duration)

(duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) Lemual Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto City Hosp.

Did an operation precede death? No Date of 3-17-1927

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Clinical Signs

(Signed) W. B. Dyckes, M.D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — Date of Burial: Apr. 12 1927

20 UNDERTAKER: Harry W. Ehlen — ADDRESS: 1944 W. North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 10 1927

Cor.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21059

CERTIFICATE OF DEATH.

x 179

E 21059

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 179 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Dorsey

(a) RESIDENCE NO. Lutherville Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Dorsey

6 DATE OF BIRTH (month, day, and year): ???? 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook (Domestic)

(b) General nature of industry, business, or establishment in which employed (or employer): 021

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER Lloyd Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER Jane Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Record Hospital

(Address)

15 Filed APR 10 1927 C. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: 2nd & 3rd degree burns over upper part of body, arms & face. Accident Using kerosene to start fire in her own home Mar 31/27 duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis duration yrs. mos. ds.

(Signed) J. H. Bacon M. D. (Coroner)

4/9/27 (Address) 508 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hereford Md. Date of Burial: 4/10/1927

20 UNDERTAKER: Mrs Geo. H. Holland ADDRESS 1631 David Hillman

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Trent

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21060

CERTIFICATE OF DEATH.

31 E 21060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2536 McCulloh ST. 13-54 WARD)

2-FULL NAME Sarah A Trent

(a) RESIDENCE NO. 2436 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 7 1851

7 AGE Years 76 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER T. Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Herman Trent (Address) 2436 McCulloh

15 Filed APR 10 1927 HARRISON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/8 1926 to 4/8 1927, that I last saw her alive on 4/8, 1927, and that death occurred, on the date stated above, at 7 m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry R Lutz M. D.

4/9, 1927 (Address) 2429 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 4/11/1927

20 UNDERTAKER Wm. Geo. H. Holland ADDRESS 1631 Druid Hill

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21061

CERTIFICATE OF DEATH.

45

E 21061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 W^m^ Caton St. 13-54 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Mary Brown

(a) RESIDENCE NO. 2317 W^m^ McDonald ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Merchant M. Brown

6 DATE OF BIRTH (month, day, and year): Oct 17. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Louis A. Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mayere Brown

(Address) 1631 Druid Hill Ave

15 Filed APR 10 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per LAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14 1927 to April 7th 1927

that I last saw h[illegible] alive on April 3d 1927

and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 1st 27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. C. Jones, M. D.

4/7/27 (Address) 9 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 4/11/ 1927

20 UNDERTAKER: Jos. Geo. H. Holland

ADDRESS: 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21062

CERTIFICATE OF DEATH.

114 E 21062

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 21062
1-PLACE OF DEATH

City of BALTIMORE: (No. 431 W. Biddle St. 11-24 Ward)

2-FULL NAME Robert Brown

(a) RESIDENCE NO. 431 W. Biddle St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Brown

6 DATE OF BIRTH (month, day, and year) May 28, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	10 11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Confectionery dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 019
(c) Name of employer Deep

9 BIRTHPLACE (city or town)_____
(State or country) Md.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town)_____
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Brooks

13 BIRTHPLACE OF MOTHER (city or town)_____
(State or country) Md.

14 Informant Mrs. Daisy Brown
(Address) 431 W. Biddle St.

15 Filed APR 10 1927 Per C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Gastro enteritis 20 hours

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ac. Dis. of Heart 5 hours

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

April 6, 1927 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn — Date of Burial 4/10 1927

20 UNDERTAKER James R. T. Hamilton — ADDRESS 431 W. Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21063

CERTIFICATE OF DEATH.

90 E 21063

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2832 Montebello St. 46 WARD)

2-FULL NAME Philip. Joseph Hunt.

(a) RESIDENCE NO 2832 Montebello St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella J. Hunt.

6 DATE OF BIRTH (month, day, and year) Aug. 23 1866.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
60	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Later

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip J Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Katherine Wee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Estella J. Hunt.

(Address) 2832 Montebello Av

15 Filed APR 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24th 1927 to April 7th 1927.

that I last saw him alive on April 7th 1927

and that death occurred, on the date stated above, at 2.30 P m

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W. Appleton M. D.

4/11/1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL April 1927

20 UNDERTAKER George J. Rust ADDRESS 1735 Hayford Av

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21064

CERTIFICATE OF DEATH.

90 E 21064

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S Eutaw ST. 22-30 WARD)

2-FULL NAME JOHN GOVORUHK

(a) RESIDENCE No. 600 S Eutaw ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7. 1914

7 AGE 12 Years 6 Months 2 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Govoruhk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russin

12 MAIDEN NAME OF MOTHER E. Sawin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russin

14 Informant Jacob Govoruhk
(Address) 600 S Eutaw Street

15 Filed 10 1927, 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1926, to 4/9, 1927, that I last saw h— alive on 4/9 1927 and that death occurred, on the date stated above, at 10 P. m

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine + Consultation

(Signed) David Framer M. D.

4/10, 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Indepedet	April 11. 1927
20 UNDERTAKER	ADDRESS
John Grebliauskas J G	423 S Paca St.

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21065 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 21065

1-PLACE OF DEATH Mercy Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Emory Elliott

(a) RESIDENCE NO. 1557 N. Gilmor ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gillian C. Elliott

6 DATE OF BIRTH (month, day, and year) Dec 28 1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
30	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Emory P. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Coralee Rohrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Gillian C. Elliott 1557 N. Gilmor.

15 Filed APR 11 1927 C. HAMPTON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1926, to Apr. 7, 1927.

that I last saw him alive on Apr. 7, 1927.

and that death occurred, on the date stated above, at 12:20 a. m.

The CAUSE OF DEATH* was as follows:

Lupus - carcoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? —

(Signed) Thos. B. Turner M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mass. D.C. Arlington National Cem. Arlington Va

DATE OF BURIAL 4-11 1927

UNDERTAKER Ernest Harke

ADDRESS 115 E Watts

ATTENTION is very important. See instructions on back of certificates.

Ella E. Mohler.

Spec.–7-17-26—A Co.—200 Bks.

E 21066

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21066

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union memorial Hospital REGISTERED NO. 47

City of BALTIMORE: (No. 1 St. 12-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs I. Weinhert Mohler

(a) RESIDENCE NO. Homewood Apts St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 13 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of I. W. Mohler

6 DATE OF BIRTH (month, day, and year) Jan 27 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	62	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Elzey

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Wilson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Hospital Record

(Address)

15 Filed APR 4 1927 C. HAMILTON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 4, 19 27, to April 9, 19 27,

that I last saw her alive on April 9. 19 27,

and that death occurred, on the date stated above, at 10 45 p. m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma Breast Rt.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Erysipelas arm Rt.

Terminal Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. Bedford, M. D.

, 19 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Green Mount Cemetery	4/12 1927

20 UNDERTAKER Henry H. Myers & Son ADDRESS 703 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21067

CERTIFICATE OF DEATH.

100-201

E 21067

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Florence Crittenton Mission WARD) 15-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elaine Condiff

(a) RESIDENCE NO. Florence Crittenden Mission ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1927

7 AGE	Years	Months	Days 16	If LESS than 1 day, ... hrs. or ..... min.
		1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Erwin Reichard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mable Condiff

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Annie E. Gerber

(Address) 32 W Chestnut Ave

15 Filed APR 7 1927, 19 C. HAMILTON JONES, M. D. Registrar

By RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to apr 10, 1927,

that I last saw her alive on apr 9, 1927

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John E Baldwin, M. D.

19 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL April 11 1927

20 UNDERTAKER Chas E. Franck & Son ADDRESS Mediavue

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION OF SECTION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 21068

CERTIFICATE OF DEATH

E 21068

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 447 N Lakewood Ave 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Hammel

(a) RESIDENCE NO. 447 N Lakewood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 12-1925

7 AGE: Years 2 Months 2 Days 27 IF LESS than 1 day.....hrs. or.....min.. 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER George F Hammel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A McCabe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant George F Hammel

(Address) 447 N Lakewood

Filed APR 11 1927 19 C. HARRY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 27, 19.., to April 9 27, 19..

that I last saw her alive on April 8 19 27

and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH was as follows:

Influenza

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Ida Burstein M. D.

19 27 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

Date of Burial: Apr 11 1927

20 UNDERTAKER: John Ulrich

ADDRESS: 2615 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002

21069 E 21069

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3704 Mt Pleasant Ave Ward 26-37)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Mardaga

(a) RESIDENCE NO. 3704 Mt Pleasant Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Apr. 7 1927

7 AGE: Years | Months | Days: 3 | IF LESS than 1 day hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Thos Mardaga

11 BIRTHPLACE OF FATHER (City or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER Florence Kristerson

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Thos Mardaga

(Address) 3704 Mt Pleasant Ave

15 Filed APR 11 1927, 19 — C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 10-1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 10, 1927, that I last saw him alive on April 10, 1927 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Disease

(Patent Foramen Ovale)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Kelly, M. D.

4/10, 1927 (Address) 2500 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — Date of Burial: Apr 12 1927

20 UNDERTAKER: John Merrick — ADDRESS: 2008 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21070

CERTIFICATE OF DEATH

129

REGISTERED NO. E 21070

1-PLACE OF DEATH Augusta & Lexington

City of BALTIMORE: (No. Bethel Home St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Jones

(a) RESIDENCE NO. 207 Augusta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1851

7 AGE: Years 76 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (City or town) unk

(State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk

(State or country)

14 Informant Mrs Mary Handy

(Address) 207 Augusta

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1927, to April 8, 1927, that I last saw her alive on April 8, 1927, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart Interstitial Nephritis

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Scott Allen, M. D.

April 11 1927 (Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 4-11 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

2.1071

E ~~21071~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21071

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Harlem ave. St., 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Black.

(a) RESIDENCE NO. 1704 Harlem ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 16-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	24 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Peter A. Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Jas. A. Black 1704 Harlem ave.

15 Filed 4/9, 1927 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9- 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar. 7- 1927 to Apr. 9- 1927, that I last saw h alive on Apr. 9- 1927, and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam,

(Signed) Paul Clowes M. D.

4/9, 1927 (Address) 1837 Penna ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balt. Cem DATE OF BURIAL April 2 1927

20 UNDERTAKER Geo. H. Little ADDRESS 2700 Edmondson ave

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

E 21072

CERTIFICATE OF DEATH.

65-001 E 21072

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 12-49 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Pholen

(a) RESIDENCE NO. 321 E. 41st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Hamil

6 DATE OF BIRTH (month, day, and year): Sept 8 1864

7 AGE — Years: 42 Months: 6 Days: 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md -

(State or country)

PARENTS

10 NAME OF FATHER: William Mason

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unknown

14 Informant: Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... C. HAMILTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1927, to Apr. 8, 1927, that I last saw her alive on Apr. 8, 1927, and that death occurred, on the date stated above, at 9 a- m.

The CAUSE OF DEATH* was as follows:

Leukaemia - Acute myelogenous

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death! Yes Date of 4 [illegible]

Was there an autopsy! Yes.

What test confirmed diagnosis! Blood -

(Signed) E Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial April 11 19 27

UNDERTAKER: Mary M Wiedefeld ADDRESS 501 E 32nd St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21073

CERTIFICATE OF DEATH.

E 21073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2775 N. North Ave St. 15-68 Ward)

2-FULL NAME Martha Cook

(a) RESIDENCE NO. 2775 N. North Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentine Cook

6 DATE OF BIRTH (month, day, and year) Aug 15, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Joseph A. Jones (Address) 2775 N. North Ave

15 Filed ....., 19.. C. HARRY ....., M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jurors (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 1 hr (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Marasmus (duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Harry Hamilton M. D. (Coroner)

Apr 7 19 27 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Apr 11 19 27

20 UNDERTAKER Wm. Cook ADDRESS 502 E North Ave

APR 11 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Dr Magnus 16 E. Read St

HEALTH DEPARTMENT—CITY OF BALTIMORE

-164 E 21074

CERTIFICATE OF DEATH

E 21074

1-PLACE OF DEATH

REGISTERED NO. 27-4

City of BALTIMORE: (No. 3434 Belair Rd St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kistner

(a) RESIDENCE NO. 3434 Belair Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Kistner

6 DATE OF BIRTH (month, day, and year): June 30, 1846

7 AGE: Years 80 Months 9 Days 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: John Herkenheim

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Herkenheim

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Henrietta Kuhn

(Address) 3434 Belair Rd

15 Filed APR 11 1927 HARRISON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 12th, 1927, to Apr 8. 1927.

that I last saw h[illegible] alive on Apr 8. 1927.

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Thos. D. Magnus, M. D.

, 19 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial: Apr 11 1927

20 UNDERTAKER: Hudson Cook ADDRESS 507 E Baltimore

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. OF DEATH

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21075

CERTIFICATE OF DEATH.

31

E 21075

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jos Porzorecky or Kiewierski

(a) RESIDENCE NO. 723 S. Bond St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 14 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Jacob Kiewierski

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14 Informant Dan Habinet

(Address) 723 S. Bond.

15 Filed _____ 19____ C. HAMILTON JONES, M. D.

Per K.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 8, 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1927 to April 8, 1927, that I last saw h[illegible] alive on April 8, 1927, and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Lung Abscess (Pulmonary suppuration

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pulmonary Haemorrhage

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 4-4-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) H. Edmund Penn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

A.A.Co. Russian Cem Stoney Run April 12 '27

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1627-001

E 21076

CERTIFICATE OF DEATH.

E 21076

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 529 N. Gilmor St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Ellis

(a) Residence No. 529 N Gilmor St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, white | 5-Single, ~~Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 9. 27

7-AGE. ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, 14 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country).....

PARENTS

10-NAME OF FATHER Winfield Ellis

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Magdalene Spousel

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Magdalene ~~Ellis~~ Ellis

(Address) 529 N. Gilmor St.

15- Filed APR 1 1927 C. HAMPSON JONES, M. D., Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 10. 27

17- I HEREBY CERTIFY, That I attended deceased from April 9 1927 to April 10 1927

that I last saw h... alive on April 10 1927

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J Rippaver M. D.

(Address) 8 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, April 11 1927
Baltimore Cemetery	
20-UNDERTAKER.	ADDRESS
Thos C. Miller & Son	2334 E. Jefferson St

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21077

CERTIFICATE OF DEATH.

E 21077

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2711 Guilford Ave. WARD) 17-50 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter N. Watson

(a) RESIDENCE NO. 2711 Guilford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J. Watson

6 DATE OF BIRTH (month, day, and year) May. 27. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Y. W. C. A.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bolivar W. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Heath

(Address) 2711 Guilford Ave.

15 Filed APR 11 1927 C. HAMILTON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1927.

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1927. to Apr 9, 1927.

that I last saw him alive on Apr 9, 1927.

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with Chr. Nephritis, (duration) yrs. mos. ds.

18 Where was disease contracted (or) if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Hyde, M. D.

Apr. 10. 1927 (Address) 1108 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Apr 12 1927

20 UNDERTAKER Mr. Mrs. J. W. Teufel & Son ADDRESS 801 N. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21078

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21078

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE (No. [illegible] St. [illegible] Ward) 1631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Parr

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married Divorced

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Virginia M. Parr

6 DATE OF BIRTH (month, day, and year) Aug. 30 1890 ?

7 AGE: Years 36; Months 7; Days 10; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER J. M. Parr

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) ? Md

12 MAIDEN NAME OF MOTHER Mary Rausch

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) ? Md

14 BALTIMORE CITY HOSPITALS Informant

(Address) Records

15 Filed C. Harrison Jones M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/1927

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1927, to April 10, 1927, that I last saw him alive on April 10, 1927, and that death occurred, on the date stated above, at 10.00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General - Sale

(Signed) C. Jones Bond, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Apr. 13 1927

20 UNDERTAKER Henry Hoerdt Son ADDRESS 1201 E Eager

OF DEATH is plain and full, so that it may be properly classified. Every statement of OCCUPATION is very important. See instructions on back of certificates.

ORT 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21079

CERTIFICATE OF DEATH

E 21079

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 928 N. Eden St. (Ward) 10 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Rosenberger

(a) RESIDENCE NO. 928 N. Eden St. Ward 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of: Anna E. Rosenberger

6 DATE OF BIRTH (month, day, and year): October 9 1881

7 AGE — Years: 45 Months: 6 Days: 2

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Assistant foreman for

(b) General nature of industry, business, or establishment in which employed (or employer): Greif Bros Clothing

(c) Name of employer

086

9 BIRTHPLACE (city or town): Balto. (State or country): Md

PARENTS

10 NAME OF FATHER: Louis Rosenberger

11 BIRTHPLACE OF FATHER (City or town): Balto. (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Phillmann

13 BIRTHPLACE OF MOTHER (city or town): Germany (State or country)

14 Informant: Mrs. Anna E. Rosenberger

(Address) 928 N. Eden St.

15 Filed APRIL 1927 By

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1927, to April 10 1927, that I last saw him alive on April 10 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

April 11 1927 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

Date of Burial: Apr. 13 1927

20 UNDERTAKER: Henry Houck & Son

ADDRESS: 1301 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 21080

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21080

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1033 Somerset St., 10-14 Ward)

REGISTERED NO. 175

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Leach

(a) RESIDENCE NO. 1033 Somerset St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 10 mos. 6 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1920

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	6	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence L. Leach

11 BIRTHPLACE OF FATHER (City or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Boroman

13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co.
(State or country) Md

14 Informant Mrs. Clarence L. Leach
(Address) 1033 Somerset

15 Filed APR 11 1927, 19 . H. HARRISON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year) April 10 19 27

t7 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 10, 19 27, that I last saw him alive on April 10 19 27, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Ptomaine poisoning

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Leo Mangano, M. D.

4/11, 1927 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Lawn Cemetery Date of Burial Apr. 12 1927

20 UNDERTAKER Henry Stocksdale Inc ADDRESS 1011 E. Fayette

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Be sure DISEASE CAUSING DEATH is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21081

E 21081

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucile Morris

(a) RESIDENCE NO. Chicamuxen & Belair Rd St. Belair Ward Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-7-26

7 AGE — Years: 9 mos. 0 | Months: 10 | Days: 3 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Belair

(State or country) Md

PARENTS

10 NAME OF FATHER Lewis Morris

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Eliz Bond

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 11 1927, 19 C. HAMPSON JONES, M. D. Registrar

By KM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to April 10, 1927,

that I last saw h.e. alive on April 10, 1927,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis (Lungs)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Laboratory & X-ray.

(Signed) J. O'Brien, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hender Hill — Date of Burial: Apr 12 1927

20 UNDERTAKER: Dennis Foster — ADDRESS: Belair Md

IF DEATH is plain form, so that it may be properly classified. Take statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21082

131

CERTIFICATE OF DEATH.

REGISTERED E 21082

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 523 N. Ellwood Ave St., 7-11 Ward)

2-FULL NAME Harry P. Poole

(a) RESIDENCE NO. 523 N. Ellwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Myrtle E Poole

6 DATE OF BIRTH (month, day, and year): Dec 17/88

7 AGE: 38 Years 37 | Months 3 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Con. Gas El. & Co

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Chas. P. Poole

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Lottie R. Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Myrtle E. Poole

(Address): 523 N. Ellwood

15 Filed APR 11 1927, 19

C. HAMPSON JONES, M. D.

Per K H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 9/27, 19

17 I HEREBY CERTIFY, That I attended deceased from March 27, 19, to April 9, 1927,

that I last saw h[illegible] alive on April 8, 1927,

and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Polycystic Kidney

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 408 E Pat Pl Ba

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — Date of Burial: 4/12/27

20 UNDERTAKER: Philip Henry Orleans — ADDRESS 3016

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21083 **E 21083**

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 506 Gold (St.) 14-20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Berry

(a) RESIDENCE NO. 506 Gold ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex Male X

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Narcissa Berry

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jno W Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elnora Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Narcissa Berry

(Address) 506 Gold St.

15 Filed APR 11 1927 Per H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 1927, to 4/8, 1927, that I last saw him alive on 4/8, 1927, and that death occurred, on the date stated above, at 7.30 P m

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency *

Acute myocarditis.

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Lutes, M. D.

4-8 1927 (Address) 2134 Dr. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4/11 1927

20 UNDERTAKER Samuel J Hemsley

ADDRESS 578 N Bradford

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

109-002

E 21084

CERTIFICATE OF DEATH.

E 21084

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Pennington Av St. 5-17 Ward)

2-FULL NAME Jack M. Masters

(a) RESIDENCE NO. 1709 Pennington Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 2/24

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	3	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Chas. E. Masters

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Florence A.

13 BIRTHPLACE OF MOTHER (city or town): Minnick

(State or country): Penna

14 Informant: Chas. E. Masters

(Address): 1709 Pennington Ave

15 Filed APR 11 1927 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10/27

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to April 10, 1927, that I last saw him alive on April 10, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis Acute Rheumatism + Endocarditis

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alvin B Lennard, M. D.

(Address) 718 W Pittsburgh Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leader Hill — Date of Burial: 4/12 1927

20 UNDERTAKER: Philip Hennig — ADDRESS: 2017 Orleans

OF DEATH is plain, legible, and that in any of the spaces. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21085

CERTIFICATE OF DEATH.

E 21085

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40th St. & Cedar Ave ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Rowe

(a) RESIDENCE NO. Home for Incurables ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Ust yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert S. Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredericksburg Va

12 MAIDEN NAME OF MOTHER Fannie Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Home for Incurables (Address) 40th St. & Cedar Ave

15 Filed ....., 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1924 to April 10 1927.

that I last saw her alive on April 10 1927.

and that death occurred, on the date stated above, at 4.05 p. m.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

over 10 yrs. 5 mos ds. (duration)

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) — yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical clinical diagnosis

(Signed) W. W. Mayo, M. D.

4/10, 1927 (Address) Latrobe Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Apr 12, 27

20 UNDERTAKER Wm Tucker & Sons

ADDRESS North Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21086

CERTIFICATE OF DEATH.

E 21086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2526 Annah Ave. ST. 16-68 47 WARD)

2-FULL NAME Ida Waidner Harwood

(a) RESIDENCE NO. 2526 Annah Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Harwood.

6 DATE OF BIRTH (month, day, and year) June 21 1874

7 AGE — Years: 52 — Months: 9 — Days: 18 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. W. Waidner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Jane Drew

13 BIRTHPLACE OF MOTHER (city or town) Chicago (State or country)

14 Informant Mr. Wm Harwood

(Address) 2526 Annah ave.

15 Filed APR 11 1927 HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov - 1, 1926, to Apr - 8, 1927.

that I last saw h[illegible] alive on Apr - 8, 1927

and that death occurred, on the date stated above, at 4.30 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast with Metastasis of Lungs & Spinal Cord,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. M. Steele, M. D.

(Address) 8064 Fullerton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. — DATE OF BURIAL: Apr. 11 1927

20 UNDERTAKER: Wm Pickuer Sons — ADDRESS: Montebello

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21087

CERTIFICATE OF DEATH.

74 E 21087

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 S. Collington Ave. St., 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Leete

(a) RESIDENCE NO. 229 S. Collington Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas H. Leete.

6 DATE OF BIRTH (month, day, and year): Feb-13-1835

7 AGE: Years 92 | Months 1 | Days 24 | IF LESS than 1 day.....hrs. or.....min. 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): New Haven

(State or country): Conn.

PARENTS

10 NAME OF FATHER: Silas Way

11 BIRTHPLACE OF FATHER (city or town):

(State or country): England.

12 MAIDEN NAME OF MOTHER: Eunatia Sullivan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland.

14 Informant: Clayton H. Leete.

(Address) 229 S. Collington Ave.

15 Filed APR 11 1927 H. [illegible] JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7-1927

17 I HEREBY CERTIFY, That I attended deceased from Dec - 1926, to April 7, 1927, that I last saw h- alive on April 7, 1927, and that death occurred, on the date stated above, at 11 00 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteri-Sclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Chas F. Block, M. D.

, 19 (Address) 25 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Conn. Date of Burial April 11 1927

20 UNDERTAKER: Lilly and Zeiler ADDRESS 403 S. Wolfe St.

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21088 1-PLACE OF DEATH

98 **E 21088** REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospital 6-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Duncan - 2

(a) RESIDENCE NO. Lynder Ave. Broadway & Rd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Scotland.

(State or country)

PARENTS

10 NAME OF FATHER: John Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Mozart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mary Duncan.

(Address): Edgemere Balto Co.

15 Filed....., 19..... Per ..... Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-9-27

17 I HEREBY CERTIFY, That I attended deceased from 3-5 1927 to 4-9- 1927 that I last saw him alive on 4-9- 1927 and that death occurred, on the date stated above, at 7:15 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Cirrhosis Kidneys

Chronic Myocarditis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-8-27

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. Haycock, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Apr. 12 1927

Date of Burial

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 S Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21089

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hipkins Hospital St. 76-37 Ward 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Schuman

(a) RESIDENCE NO. 3705 E. Pratt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of XXX X

6 DATE OF BIRTH (month, day, and year) May 23/25

7 AGE	Years	Months	Days 15	IF LESS than 1 day.....hrs. or.....min.
	1	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph C.Schuman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Louise Gross

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Joseph C.Schuman

(Address) 3705 E. Pratt St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oil of Wintergreen Poisoning

Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Pate, M. D.

(Coroner)

4/9/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Bath Lawn Cem. April 11 1927

20 UNDERTAKER ADDRESS

Lilly & Feiler 403 S Wolfe St

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 **E 21090**

REGISTERED NO.

E 21090

1-PLACE OF DEATH

City of BALTIMORE: (No. 1046 Lexington St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Parker

(a) RESIDENCE NO. 1046 Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Parker

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 23

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER Katie Byers

13 BIRTHPLACE OF MOTHER (city or town) Wash.

(State or country) D.C.

14 Informant Thos Taylor

(Address) 918 W Lexington Sts

15 Filed ....., 19.... C. Hamilton Jones M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 1926, to April 10, 1927, that I last saw h..... alive on April 7, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of? No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Howard Taylor, M. D.

April 12, 19 (Address) 913 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn Cemetery	April 13 1927
20 UNDERTAKER	ADDRESS 322 N Schroeder St
Mrs. Katie R. Williams	

Of Health in plain terms, as they will be required by law. Physicians are requested to report causes of certificates.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21091

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 21091

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1023 Booth ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Bryan

(a) RESIDENCE No. 1023 Booth ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jany 17. 1902

7 AGE: Years 25 Months 2 Days 21 (20) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Upholstering

(c) Name of employer: Murphy Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Cecilia Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jasse Howard Co Md

14 Informant: Ruth Howard

(Address) 1031 Booth St

15 Filed APR 1 1927 By R.H. Registrar

S. HAMILTON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 1. 1927. to April 7 1927.

that I last saw her alive on April 6. 1927.

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Rodill M. D.

4/11/1927 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: April 11, 1927

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21092

E 21092

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 425 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Watts

(a) RESIDENCE NO. Arthur Hotel, Howard & Mulberry Sts.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49		17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Newspaper
(c) Name of employer So. Plants Pub. Co.

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Jas. Watts
11 BIRTHPLACE OF FATHER (City or town) Baltimore, Md
(State or country)
12 MAIDEN NAME OF MOTHER Mary McAllister
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant George Watts
(Address) 235 St. Paul St.

15 Filed APR 1 1927, 19 HAMILTON JONES, M. D. Registrar
By RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1927, to Apr 9, 1927, that I last saw him alive on Apr 9, 1927, and that death occurred, on the data stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 3 weeks
Jaundice Lues ?
Chr Alcoholism ?

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No. Data of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E K Muller, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Pk. Cem	Apr 12 1927
20 UNDERTAKER	ADDRESS 420
McGinnis & Carroll, Inc	Ridgewood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

(Ray Mar Ave)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21093

1-PLACE OF DEATH

near Belair Rd + Southern Ave

129

E 21093

REGISTERED NO.

City of BALTIMORE: (No. 14 Raymar Ave 26-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle M. Conner

(a) RESIDENCE NO. 14 Raymar Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Mall	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A. Conner

6 DATE OF BIRTH (month, day, and year) Oct. 12/1872

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
54	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gas Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 33

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John A. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie E. Rudolph

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant William Conner

(Address) 3213 Reisterstown Road

15 Filed APR 11 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/26 1927, to 4/9, 1927, that I last saw h alive on 4/9 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY Convulsions

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D Conner, M. D.

1927 (Address) Conn & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rd Cem Date of Burial April 13 1927

20 UNDERTAKER Jos J Hess & Son ADDRESS 152 Eutaw

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21094

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21094

CERTIFICATE OF DEATH.

12-50 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 E. 22nd ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Krout

(a) RESIDENCE NO. 418 E. 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Krout

6 DATE OF BIRTH (month, day, and year): Oct 29 1865

7 AGE: Years 61 Months 5 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John M. Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Thalheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. J. Krout (Address) 418 E. 22nd St.

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 5, 19 27, to April 10, 19 27

that I last saw him alive on April 10, 19 27

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Intramedullary Lymphosarcoma Duodenal Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Taylor, M. D.

19 (Address) 582-E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Apr. 13. 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Greenmount Ave

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—Co.—300 Bks.

E 21095

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 21095

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 16-67

City of BALTIMORE: (No. 950 Franklin Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Cordray

(a) RESIDENCE NO. 950 Franklin Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret J. Cordray

6 DATE OF BIRTH (month, day, and year): Sept 13 1860

7 AGE: Years 65 Months 6 Days 27 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): Tin Specialties

(c) Name of employer: Nat'l Enam,& Stamping Co.

9 BIRTHPLACE (city or town) ...

(State or country): Illinois

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country): Not Known

14 Informant: Leroy H. Cordray

(Address): 950 Franklin Road

15 Filed ... 19 ... Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 20 1927 to April 9th 1927

that I last saw him alive on Apr. 8 1927

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Kidneys

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. F. Hawkins M. D.

4/11. 1927 (Address) 1 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Apr 12 1927

20 UNDERTAKER: John A. Denny — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21095

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Glyndon Ave. 21-29 44

CITY OF BALTIMORE: (No. 1348 Glyndeny ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antany Simanatis

(a) RESIDENCE No. 1348 Glyndeny ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) No. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	-	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Talor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER G. Simanatis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER G. Luksute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant G. Simaitone

(Address) 1343 Glyndeny St.

15 Filed C. HAMILTON JONES, M. D.

APR 1927 or [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1927 to Apl. 9 1927

that I last saw h[illegible] alive on Apl. 9 1927

and that death occurred, on the date stated above, at (h)

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Rukuonn

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Robt. E. Blake M. D.

, 19 (Address) 1014 N Ha[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL April 12 1927

20 UNDERTAKER John Grebliunas ADDRESS 423 S. Paca St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21097
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

38 E 21097
REGISTERED NO.

City of BALTIMORE: (No.) Baltimore City Hospitals St. (22-30) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Myers

(a) RESIDENCE NO. 420 Eisler st. St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870 ?

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	57 ?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jerry Myers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address)

Filed APR 11 1927 C. H. [illegible] Registrar
Per K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21 1927 to April 8, 1927, that I last saw h in alive on April 8, 1927, and that death occurred, on the date stated above, at 12.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Syphilis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted? Unknown
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlin, M. D.
4-8-, 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial
Ft. Lincoln Cemetery 4/11/1927

20 UNDERTAKER ADDRESS
Drue & Hooper 405 Gay St.

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21098 E 21098

CERTIFICATE OF DEATH.

REGISTERED NO. 1355

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3813 Roland Ave ST. 13 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Melvin Mildred Johnson

(a) RESIDENCE. No. 3813 Roland Ave ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Mulatto	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Melvin Johnson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mildred M Phipps

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Melvin Johnson
(Address) 3813 Roland Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from April 8 1927, to April 8 1927, that I last saw h alive on April 8 1927, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.
Pneumonia complicating Prematurity
6 hours

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) (Toxemia of pregnancy)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R B Nowmut M. D.

April 9 1927 (Address) 324 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	19
20 UNDERTAKER	ADDRESS
Cole-Clough Funeral	

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21099 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 1357

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Bauer

(a) RESIDENCE NO. 1304 Union ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) uncertain

7 AGE About 40 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dep. Coroner. (Address)

15 Filed APR 1 1927 19 C. HAMILTON JONES, M. D. Registrar Per H.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/19/27, 19 . to 4/9/27, 19 .

that I last saw him alive on 4/9/27, 19 .

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema. (Pneumococcus)
Operated 3/28/27

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonitis Pneumococcus

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/2/27

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) W. Wallace Walker, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 4/11 1927

20 UNDERTAKER J. F. Thompson ADDRESS 61 Light St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-21100

CERTIFICATE OF DEATH.

31 E 21100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals Ward) 27-6

2-FULL NAME John Smith

(a) RESIDENCE NO. 38 E Pleasant St. Ward

(Usual place of abode)

Length of residence (in city or town where death occurred) 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1859

7 AGE: Years 68 Months Days

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Hospital Records

(Address)

Filed 1-1-1927, 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from December 6, 19 26, to June 10, 19 27,

that I last saw h[illegible] alive on June 8, 19 27,

and that death occurred, on the date stated above, at 5 45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Pneumonia

& Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

Is Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial April 12, 1927

20 UNDERTAKER: F. A. Krauss & Son ADDRESS 703 Hamilton

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21101

CERTIFICATE OF DEATH

E 21101

REGISTERED NO. 15558

1-PLACE OF DEATH

City of BALTIMORE: (No. 2928 Residence St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Saunders Grobaker

(a) RESIDENCE NO. 3928 Reisterstown Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Edward S. Grobaker

6 DATE OF BIRTH (month, day, and year): Dec 4th 1867

7 AGE: Years 59 Months 4 Days 6

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Great Mills

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm F Saunders

11 BIRTHPLACE OF FATHER (City or town): Great Mills

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary E. Saunders

13 BIRTHPLACE OF MOTHER (city or town): Great Mills

(State or country): Maryland

14 Informant: E. S. Grobaker

(Address): 3928 Reisterstown Road.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/12/26, 19, to 4/10/27, 19, that I last saw h alive on 4/9/27, 19, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Febeling & Heller

(Signed) Arthur Elliott Lurd, M. D.

19 (Address) 540 Fearet Tower

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interment - Date of Burial: April 12 1927

20 UNDERTAKER: H Cole & Son ADDRESS:

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21102

CERTIFICATE OF DEATH 159-002

E 21102

1-PLACE OF DEATH

REGISTERED NO. 7

City of BALTIMORE: (No. Univ. Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Wesley Russell

(a) RESIDENCE NO. Irvington, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant.

6 DATE OF BIRTH (month, day, and year) Oct 9, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		6	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant - dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Irvington, Md

(State or country)

PARENTS

10 NAME OF FATHER Harry W Russell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Florence Isennock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mother

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

11 1927 Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 19, 1927, to April 11, 1927, that I last saw h alive on April 11, 1927, and that death occurred, on the date stated above, at 10:15 A m.

The CAUSE OF DEATH* was as follows:

Congenital cardiac Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY Rickets, malnutrition,

(Secondary) Indigestion (Chr intestinal)

(duration) yrs. 5 mos ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elizabeth Sherman, M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Date of Burial) Chestnut Grove Cemetry April 13 1927

20 UNDERTAKER Clarence C. Luther ADDRESS Fork Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21103 E 21103

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2543 Aisleton St. (Ward) 20-16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian F. Kernan

(a) RESIDENCE NO. 2543 Aisleton St., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert D. Kernan

6 DATE OF BIRTH (month, day, and year): May 25th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm. F. Eppley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Gertrude Stiffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant (Address): Wm. F. Eppley 2543 Aisleton St.

15 Filed 1927 .19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from August 1 .1926. to April 7 .1927.

that I last saw her alive on April 7-30 19..

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Hepatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Mallie Lilly, M. D.

4/11 1927 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 12th 1927

20 UNDERTAKER: F. D. Kluttz — ADDRESS: 850 W. Baltimore

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21104

CERTIFICATE OF DEATH

E 21104

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 206 Church Ave. St. Violetsville Ward) 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret R. Ridgell.

(a) RESIDENCE NO. 206 Church Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Ridgell.

6 DATE OF BIRTH (month, day, and year) Feb, 27, 1876.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	51,	1,	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Mitchell Carroll.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Calvert CO. Md.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co. Md.

14 Informant John W. Ridgell.

(Address) 206 Church Street.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RFB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 10, 1927,

that I last saw h-2 alive on April 10, 1927,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R Gustav Ridgell, M. D.

4/11, 1927 (Address) 1004 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St Pauls Cemetery Calvert Co Md	April 12 1927
20 UNDERTAKER	ADDRESS
A. Howard Evans	838 Fulton Ave

OF DEATH in plain terms. So that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21105

CERTIFICATE OF DEATH

31

E 21105

1-PLACE OF DEATH

Violetville 25-12

City of BALTIMORE: (No. 206 Church Ave. St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny C. Lusby.

(a) RESIDENCE NO. 206 Church Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R. Lusby.

6 DATE OF BIRTH (month, day, and year): March, 5, 1900.

7 AGE: Years 27, Months 1, Days 5. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Md.

PARENTS

10 NAME OF FATHER: John W. Ridgell.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Margaret R. Ridgell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md.

14 Informant: Charles R. Lusby.

(Address): 206 Church Ave.

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 1927 to April 10 1927

that I last saw h alive on April 10 1927

and that death occurred, on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Kenneth Kirsten M. D.

19 (Address) April 10 1927 2321 East Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Cem Catonsville Md Date of Burial: April 12 1927 19

20 UNDERTAKER: A Howard Evans ADDRESS: 388 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

21106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 21106

1-PLACE OF DEATH U. S. Marine Hospital No 51

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME O'Neal Robertson

(a) RESIDENCE NO. Donaldsonville, La ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman O&G

(b) General nature of industry, business, or establishment in which employed (or employer) S/S El Estero

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER John Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER — Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisana

14 Informant (Address) Hospital Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1926, to April 7, 1927, that I last saw him alive on April 7, 1927, and that death occurred, on the date stated above, at 12-53 (?) m,

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & Laboratory Exam

(Signed) W W Beeler M. D.

4-7, 1927 (Address) Asst Surgeon U.S.P.H.S. U. S. Marine Hospital - Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill. Locust Grove

DATE OF BURIAL April 12 1927

20 UNDERTAKER E Le Roy Steffen

ADDRESS 125 North Ave

Spec.—1-12-23—M&T—500 Blks.

E 21107

HEALTH DEPARTMENT—CITY OF BALTIMORE

124 E 21107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Aisquith (St.) 9-47 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ellen McCourt

(a) RESIDENCE NO. 2254 Cecil Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced, HUSBAND of or) WIFE of: Peter J. McCourt

6 DATE OF BIRTH (month, day, and year): — — 1869

7 AGE: Years 58 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Matthew Tobin

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Coleman

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

14 Informant (Address): Address Unknown

Filed 1 1927 C. HAMPSON JONES, M. D. Registrar

Per Rch

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 - 11 - 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927, to April 11, 1927.

that I last saw her alive on April 11, 1927.

and that death occurred, on the date stated above, at 3.30 PM m.

The CAUSE OF DEATH* was as follows:

Chr. Cholecystitis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): Atrum. Bronc. Pneu.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/8/27

Was there an autopsy? No Clinical Oper.

What test confirmed diagnosis?

(Signed) H. R. McConnell M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Hope Cem

DATE OF BURIAL: 4/13 19 27

20 UNDERTAKER: J. F. Thompson

ADDRESS: 1812 Eutaw Pl.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21108 44 E 21108

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1536 John St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maye F. Routh

(a) RESIDENCE NO. 1536 John St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Groceries

(c) Name of employer Self

9 BIRTHPLACE (city or town) Ottawa

(State or country) Canada

PARENTS

10 NAME OF FATHER Alexander J. Routh

11 BIRTHPLACE OF FATHER (City or town) Hamilton

(State or country) Canada

12 MAIDEN NAME OF MOTHER Harriet M. Routh

13 BIRTHPLACE OF MOTHER (city or town) London

(State or country) Canada

14 Informant Nellie M. Routh

(Address) 1536 John Street

15 Filed APR 11 1927 16 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April, 10th. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1927 to April 10th, 1927

that I last saw her alive on April 7th, 1927

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
– ascites & Jaundice

(duration) 5 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Valvular Heart – (Mitral)

(duration) 6 yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs

(Signed) D. A. Waldran, M. D.

4/11. 1926 (Address) 210 E. Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery.	Apr. 13th 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Calvert St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21109

CERTIFICATE OF DEATH

90 E 21109

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Tucker Avenue (Hillsdale St. 65 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisey D. Leaf

(a) RESIDENCE NO. Tucker Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marshall H. Leaf

6 DATE OF BIRTH (month, day, and year) January, 16" 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) Frederick, Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Jaushia Whitemore

11 BIRTHPLACE OF FATHER (City or town) Frederick Co.

(State or country) Md

12 MAIDEN NAME OF MOTHER Laura Elliott

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.

(State or country) Md.

14 Informant Wrs William Shaffer

(Address) Woodlawn Md.

15 Filed 1927 19 J. HAMPSON JONES, M. D. Registrar

By MCH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 8th. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 17 1926, to April 8th 1927, that I last saw h[illegible] alive on April 8th 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Trouble & asthma

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo L. Eberhard, M. D.

4/9. 1927 (Address) Woodlawn. Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

Date of Burial Apr. 12th 27

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 N Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21110

CERTIFICATE OF DEATH.

167-001

E 21110

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 Longwood St. 1667 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David E. Hertz Sr.

(a) RESIDENCE NO. 1200 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther J. Hertz

6 DATE OF BIRTH (month, day, and year) January 31st. 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assist. Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Steam cars

(c) Name of employer B & O) R. R.

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER P. G. Hertz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Victorine C. Burd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant MR. P.G. Hertz

(Address) 1200 Longwood St.

15 [illegible] 1927 16 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 10th. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gas inhalation (gas stove)

five minutes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Finnegan M. D. (Coroner)

4/11. 1927 (Address 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Apr. 13, 1927

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 W. Lafayette St

CHARLES JONES, M. D.

Registrar

Apr 11

1927

If DEATH in plain terms, describing the disease, cannot be stated, cause of death may be entered in terms of the symptoms or conditions which caused death, but this is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21111

CERTIFICATE OF DEATH.

3 1

E 21111

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 W Preston St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Palmer

(a) RESIDENCE NO. 307 W Preston St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 18 1907

7 AGE: Years 18 | Months 2 | Days 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Va

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Dont know

12 NAME OF MOTHER Mattie Palmer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

PARENTS

14 Informant Aubrey Palmer

(Address) 307 W Preston St

15 Filed 12 1927 CHARLTON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21 1927, to April 10, 1927, that I last saw h[illegible] alive on April 9, 1927, and that death occurred, on the date stated above, at 10:10 P. M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis and Pulmonary Congestion

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Congestion (Duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No.

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. C. Hall, M. D.

, 19 (Address) 426 E 23 dist

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial April 12th 1927

20 UNDERTAKER: Samuel Custer — ADDRESS 916 Eager

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21112 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21112

CERTIFICATE OF DEATH.

03-31 100-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 N. Hamburg St. St. Ward)

2-FULL NAME Albert Johnson.(C)

(a) RESIDENCE NO. 211 N. Hamburg St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) March 16, 1927

7 AGE	Years	Months	Days 24	IF LESS than 1 day.....hrs. or.....min.
	0	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Pindon.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 ~~MAIDEN~~ NAME OF MOTHER Emma Johnson,(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Emma Johnson.(C)mother

(Address) 211 N. Hamburg st.

15 Filed ..... 19 ..... Registrar

R 12 1927 Per RK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto A. Reinhardt M. D. (Coroner)

4/11 1927 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Jain Date of Burial Apl 12 1927

20 UNDERTAKER R L Parham ADDRESS 1216 S Charles st.

C. HARRISON JONES, M. D.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21113

E 21113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4324 Walbrook Ave St. 28 Ward) 24-09

2-FULL NAME Johnie A. Hodson

(a) RESIDENCE NO. 4324 Walbrook Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Hodson

6 DATE OF BIRTH (month, day, and year) April 6, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58			
	69		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 03

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Operator

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Edward M Hodson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Hannah Hodson

(Address) 4324 Walbrook Ave

15 Filed APR 12 1927 C. HAMPSON JONES, M. D. RRK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.

(Coroner)

April 12, 1927 (Address) 2 For Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Apr 12 1927

20 UNDERTAKER George J. Smith — ADDRESS 1532 Holins

Be sure that every certificate is complete. See instructions on back of certificate. Every item is very important.

Spec.—7-17-26—A Co.—200 Bks.

E 21114

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21114

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Brookfield Ave St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Landrogan

(a) RESIDENCE NO. 2105 Brookfield Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice B. Landrogan

6 DATE OF BIRTH (month, day, and year) June 14 1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	77-	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationery & Printing

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Baltimore Md

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER John Landrogan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Moulton

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country)

14 Informant Elizabeth B Landrogan

(Address) 2105 Brookfield Ave

15 Filed APR 12 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from ____, 1924, to April 10, 1927, that I last saw h[illegible] alive on April 10, 1927 and that death occurred, on the date stated above, at 1240 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocardial degeneration

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible] Usual

(Signed) Flowers Mabley, M. D.

19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial April 13 1927

20 UNDERTAKER George F. Smith

ADDRESS 532 Holliday

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

E 21115

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Stewart & Widwood Ave (WARD) 47-54

2-FULL NAME Antoinette Suter.

(a) RESIDENCE NO. Stewart & Widwood Ave WARD Mt. Washington

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Suter.

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65	2	24	

8 OCCUPATION OF DECEASED (X)

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER John L. Suter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy A. Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Antoinette H. Wright (Address) Stewart & Widwood Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R 12 1927 Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to Apr 11, 1927.

that I last saw h... alive on " " , 19 .

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jno. H. Pearce M. D.

, 19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore City, DATE OF BURIAL April 12 19 27

20 UNDERTAKER John C. Mitchell ADDRESS 1900 Eutaw St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—3500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21116

E 21116

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Mercy Hospital 4-6-37

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John - Wisniski

(a) RESIDENCE No. 101 Hud St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sofia

ATE OF BIRTH (month, day, and year) 1882

GE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	5, 45			

UPATION OF DECEASED

rade, profession or ular kind of work Laborer

eneral nature of Industry, ss, or establishment in employed (or employer)

e of employer

9 BI

LACE (city or town) e or country) Poland

10 NAME OF FATHER Stanislaus

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

PARENTS

instructions on back of certificates.

14 Informant Sofia Wisniewski
(Address) 101 Hud av

15 Filed APR 2 1927 C. HAMPSON JONES, M. D.
Registrar
Per KA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927 to April 11, 1927 that I last saw h... alive on April 11, 1927 and that death occurred, o... the date stated above, at 11.05 a.m.

The CAUSE OF DEATH* was as follows:

John Wisniewski

(duration) ... yrs. ... mos ... da.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) D'Amotta, M. D.

4/11/1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 14 1927
UNDERTAKER J. W. Ozgowski	ADDRESS 1930 Eastern Av

Spec.—12-9-25—A Co.—200 Bks.

E 21117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21117

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 727 N. Port St. St. 6-10 Ward)

2-FULL NAME Stanislaus Kaminski

(a) RESIDENCE NO. 727 N. Port St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine

6 DATE OF BIRTH (month, day, and year): Unknown 1876

7 AGE: Years 51; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: John Kaminski

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Josephine Kaminski

(Address): 727 N. Port St.

C. HAMILTON JONES, M. D.

15 Filed.....19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 9-1927

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927, to April 9, 1927, that I last saw him alive on April 8, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/12/, 1927 (Address) 7529 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Date of Burial 4/12 19 27

20 UNDERTAKER: J. W. Ozazewski ADDRESS 1930 Eastern Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21118

CERTIFICATE OF DEATH.

E 21118

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Allen

(a) RESIDENCE NO. 202 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Allen

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	43 44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER George Allen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Dyson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant

(Address) Arendes

15 Filed 19 For Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1927, to April 9, 1927, that I last saw him alive on April 9, 1927, and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis, acute

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Lab.

(Signed) C. Holmes Boyd, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem Date of Burial 4/13 1927

20 UNDERTAKER Byron Wright ADDRESS 1218 McElderry St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21119

CERTIFICATE OF DEATH.

100-001

E 21119

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1060 Argyle Ave ST. 17-24 (WARD)

2-FULL NAME Nubra Loretta Floyd

(a) RESIDENCE NO. 1060 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
10 weeks	0	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edwin Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nubra Weeks

13 BIRTHPLACE OF MOTHER (city or town) Camden (State or country) N. J.

14 Informant Nubra Weeks Floyd

(Address) 1060 Argyle Ave.

Filed R.I.P. 1926 H. HAMPSON JONES, M. D.

Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to April 10, 1927, that I last saw her alive on April 10, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. Rennard, M. D.

4-11-1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery

DATE OF BURIAL: April 12, 1927

20 UNDERTAKER: Mrs. Kate R. Williams

ADDRESS: 327 N. Schroeder St

Cor.—12-9-25—A Co.—200 Bks.

E 21120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21120

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at Hopkins Hospital St., 712 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bartels

(a) RESIDENCE NO. 2714 E. Mounment St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Bartels

6 DATE OF BIRTH (month, day, and year) Nov. 18th. 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaning

(b) General nature of industry, business, or establishment in which employed (or employer) (Dept.)

(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town)_____

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Bartels

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wentzel

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Wm. N. Bartels

(Address) 2219 Lake Ave. (Mayfield)

15 Filed DEC 12 1925 C. HAMILTON JONES, M. D. Registrar

PR 12 1927 For K.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/ 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency-probably Myocardial

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Mc Cans M. D. (Coroner)

4/11/27 (Address) 508 E. Nor h Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial 4/12/27

20 UNDERTAKER P. Philips & Henrig ADDRESS 2010 Eden St.

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 21121

CERTIFICATE OF DEATH

E 21121

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 208 S. 5th St. Brooklyn 25-15 Ward.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bushman

(a) RESIDENCE NO. 208 S. 5th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Bushman

6 DATE OF BIRTH (month, day, and year): April 10 1841

7 AGE: Years 85 Months 11 Days 30 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs H. E. Gray (Address): Annapolis Blvd.

15 Filed ....., 19.... Registrar.

APR 12 1927 C. HAMPSON JONES, M. D. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 19 27, to Apr 9, 19 27, that I last saw h.. alive on Apr 9, 19 27, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. B. Woodle M. D.

, 19 27 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial: April 12 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 S. Eighth St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21122

CERTIFICATE OF DEATH.

E 21122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—NO. 321 S. Pulaski ST. (OR WARD)

2-FULL NAME Babetta H. Reich

(a) RESIDENCE NO. 321 S. Pulaski ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob J. Reich

6 DATE OF BIRTH (month, day, and year): Oct 1st 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Wendt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Huldebrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Basil Reich

(Address) 321 S. Pulaski St

15 Filed APR 2 1927 H. HAMILTON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1926, to April 9, 1927, that I last saw her alive on April 9, 1927, and that death occurred, on the date stated above, at 11:54 P.M.

The CAUSE OF DEATH* was as follows:

Central Haemorrhage

(duration) 2 yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Hew. Jolly M. D.

1927 (Address) 225 N Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: April 13th 1927

UNDERTAKER: P. B. Weyforth

ADDRESS: 1850 N. Gilmor St

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 21123

PLACE OF DEATH E 21123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1146 Nanticoke St. 21-29 (Ward)

2-FULL NAME Wilhelmina Perkins

(a) RESIDENCE NO. 1146 Nanticoke St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eugene Perkins.

6 DATE OF BIRTH (month, day, and year): June 2, 1867

7 AGE — Years: 59 — Months: 10 — Days: 8 — If LESS than 1 day, hrs or min:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Edenton N. C.

PARENTS

10 NAME OF FATHER: Thomas Gurney

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: ? Cochran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mr. Eugene Perkins 1146 Nanticoke St.

15 Filed ..., 19..., ..., Registrar

C. HAMILTON JONES, M. D.

APR 12 1927 For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1926, to April 10, 1927, that I last saw h[illegible]live on April 9, 1927 and that death occurred, on the date stated above, at 12.25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Eyser, M. D.

4/12 1927 (Address) 3901 Gaveran Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: Apr 13 27

20 UNDERTAKER: D. M. Fickert & Sons — ADDRESS: North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 21124

REGISTERED NO. E 21124

1-PLACE OF DEATH

City of BALTIMORE: (No. 732 St Peter St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles William Jones-Jr.

(a) RESIDENCE NO. 732 St Peter St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11-1927

7 AGE	Years	Months	Days	IF LESS than 1 day 2 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles William Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Clara Gutkaska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Albany N.Y.

14 Informant Charles William Jones

(Address)

15 Filed 1927 C. HAMILTON JONES M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/27 19

17

I HEREBY CERTIFY, That I attended deceased from 4/12/27, 1927, to 4/12/27, 19 27,

that I last saw h[illegible] alive on 4/12/27, 19 27

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ mo Fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

4/12, 1927 (Signed) Edward Tenny, M. D.

(Address) Gross London

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery Date of Burial April 12 1927

20 UNDERTAKER H. Sands & Son ADDRESS 1710 Fillmore St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 126 N 22nd St. 12-51 Ward)

2-FULL NAME Ellen M. Wilmer

(a) RESIDENCE NO. 126 N 22nd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 3, 1852

7 AGE: 74 Years 73 Months 8 Days 6. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Edmund Wilmer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Wyatt

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Florence Wilmer

(Address) 126 N. 22nd St. Balto. Md.

15 Filed APR 2 1927 Per C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Myocarditis

Chronic Interstitial

Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wm H Norman M. D.

(Coroner)

4/1, 1927 (Address) 3 West Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dolphwell, Fork Towson Md Date of Burial: Apr 1 1927

20 UNDERTAKER: J. F. Cook ADDRESS: 507 E. Madison

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

D 1892

E 21126

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-00E

E 21126

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

2-FULL NAME John Howard Bertrand

(a) RESIDENCE NO. 913 N. Castle St St., Ward D,

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Barbara Bertrand

6 DATE OF BIRTH (month, day, and year) Sept 22nd 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): City of Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER George Bertrand

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

APR 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17

I HEREBY CERTIFY, That I attended deceased from April 6 1927, to April 11, 1927, that I last saw h.. alive on April 11, 1927, and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer, Perforated

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Peritonitis. Pneumonia Bronchial

(duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown. Probably

Did an operation precede death? Yes Date of April 6, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Seen at operation

(Signed) Warfield M. Firor, M. D.

, 19 (Address) Hutto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 4/13 1927

20 UNDERTAKER: William Cook — ADDRESS 502 E North

very important. See instructions on back of certificates.

Mary R Brownlee.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21127

CERTIFICATE OF DEATH

E 21127

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John A. Brownlee

(a) RESIDENCE NO. Derby - New York St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. John A. Brownlee

6 DATE OF BIRTH (month, day, and year): June 15, 1885

7 AGE: 41 Years 42 Months 9 Days 28 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): New York

(State or country)

PARENTS

10 NAME OF FATHER: George W. Pearl

11 BIRTHPLACE OF FATHER (City or town): Mass.

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa Day

13 BIRTHPLACE OF MOTHER (city or town): Mass

(State or country)

14 Informant: Mr. Robt. G. Leetch

(Address) 2522 N. Charles

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

Per .....

APR 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927, to April 11, 1927, that I last saw her alive on April 11, 1927 and that death occurred, on the date stated above, at 6:45 P.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) several yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Dr. W. S. Hannah, M. D.

, 19 (Address) Union Memorial Hospital 33rd & Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Buffalo N York — Date of Burial: 4/13 1927

20 UNDERTAKER: Wareham Cook — ADDRESS: 502 E North Ave.

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21128

CERTIFICATE OF DEATH.

E 21128

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Penitentiary Hospital St., Isolation Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Norman W. Bortner

(a) Residence No. 102 E. Belvue Ave St., Ward.

(Usual place of abode) Baltimore (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Irene S. Bortner

6-DATE OF BIRTH (month, day and year) Feb. 3, 1878

7-AGE.	If LESS than 1 day.
49 yrs. 2 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundry Man

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer Anna Fell

9-BIRTHPLACE (city or town) (State or Country), Glen Loch - Pa

PARENTS.

10-NAME OF FATHER, Albert Bortner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Glen Loch Pa

12-MAIDEN NAME OF MOTHER, Lily Goodley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

11- (Informant) Irene S. Bortner

(Address) 427 E. 20th St

Filed APR 12 1927 192 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 11, 1927

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1927 to April 11 1927

that I last saw h[illegible] alive on April 11, 1927

and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombus

(Duration) yrs. mos. 1 min ds

CONTRIBUTORY (Secondary) Sarcoma Liver (Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Albert F. Anderson M. D.

4/11/27 1927 (Address) 4 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL, Apr 14, 1927

20-UNDERTAKER J. W. Cook

ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21129

CERTIFICATE OF DEATH

90 E 21129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 N. Payson St. 16-27 Ward) Derwood.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger ~~Harold~~ Jones

(a) RESIDENCE NO. 604 N. Payson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ 5-2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rosa H. Jones.

6 DATE OF BIRTH (month, day, and year) February 20 1862.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	65yr.	1	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House-painting

(c) Name of employer self

9 BIRTHPLACE (city or town) ~~Havre de Grace~~ ?

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Roger Jones.

11 BIRTHPLACE OF FATHER (City or town) T. Schuetz

(State or country) Ind.

12 MAIDEN NAME OF MOTHER Sarah Stone

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Maryland.

14 Informant Mary E. Turner.

(Address) 604 N. Payson St.

15 Filed 4 2 1927

19 C. HARRISON JONES, M. D. Registrar

Per RR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 - 1927.

17 I HEREBY CERTIFY, That I attended deceased from 4-5- 1927, to 4-11- 1927.

that I last saw him alive on 4-9- 1927.

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of Heart.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) Chester Riland, M. D.

4-11-. 1927 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

Date of Burial 4/13 1927

20 UNDERTAKER Wiseman Cook Co.

ADDRESS 502 E. North

Duplicate of certificates. See instructions on back of certificates. This space is very important.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21130

CERTIFICATE OF DEATH

90

E 21130

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 927 N Carey St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Dornmiller

(a) RESIDENCE NO. 927 N Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gephart Dornmiller

6 DATE OF BIRTH (month, day, and year) May 11, 1841

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	85	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md

(State or country)

PARENTS

10 NAME OF FATHER William Warner

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Cornelia Dornmiller

(Address) 927 N Carey St

15 Filed APR 12 1927, 19 H. M. WILKES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1927, to Apr. 8th, 1927

that I last saw h[er] alive on Apr. 8th, 1927

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Kadin, M. D.

19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Apr 12, 1927

20 UNDERTAKER W. H. Cook

ADDRESS 503 E Monument

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21131
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital
CITY OF BALTIMORE: (No.) ST., 7-11 WARD)

2-FULL NAME Charles Masopust

(a) RESIDENCE NO. 2918 McElderry St. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary A. Masopust

6 DATE OF BIRTH (month, day, and year) June 10- 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fire Insurance
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS
10 NAME OF FATHER John Masopust
11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant J. C. Masopust
(Address) 2918 McElderry St

15 Filed APR 12 1927 H. A. KOPP JONES, M. D. Registrar
By K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1927

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1927, to April 9, 1927, that I last saw h.. alive on April 9, 1927, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Prostate
Arteriosclerosis & Myocardial Degen.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. H. Mott, M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery
DATE OF BURIAL April 12 1927
20 UNDERTAKER Zirkler & Zirkler
ADDRESS 1739 E. Eager St.

TION IS VERY important

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 21132

1-PLACE OF DEATH — REGISTERED No. E 21132

City of BALTIMORE: (No.) 1729 E. Eager St. 7-13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Clark

(a) RESIDENCE NO. 1729 E. Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma V. Clark

6 DATE OF BIRTH (month, day, and year) Jan 15/1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
60	59	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Highways Dept

(c) Name of employer Balto., Md.

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benj. J. Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Susan Cole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Emma V. Clark

(Address) 1729 E. Eager St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. [illegible] Coroner M. D.

4/12/27 18 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Oak Lawn Cemetery — April 14 1927

20 UNDERTAKER — ADDRESS

Zirkler & Zirkler — 1739 E Eager St

Apr 12 1927 RM

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001

E 21133

REGISTERED NO. E 21133

1-PLACE OF DEATH

City of BALTIMORE: (No. 3330 Hudson St., 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Pinkelman

(a) RESIDENCE NO. 3330 Hudson St. 1st Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER John Pinkelman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louis Pinkelman
(Address) 3319 Hudson St

15 Filed ..... 19 C. HAMILTON JONES, M.D. Registrar
By KM

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc
Gas Poisoning 1 hr.
(duration) ..... yrs. ..... mos. 2 hrs
Asphyxia
CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. 1 hr.

Apr 1 1927 (Signed) G C Yates M. D.
(Coroner)
19 (Address) 143 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Germans Rep. Cemetery Date of Burial April 2 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

REC 1927

Very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21134

E 21134

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 Montebello Ter ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Lorraine Ditman

(a) RESIDENCE NO. 140 Montebello Terrace ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1857

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H. Ditman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lydia E. Cumer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Chas R. Ditman

(Address) 140 Montebello Terrace

15 Filed [illegible], 19 [illegible] Registrar

C. HAMILTON JONES, M. D.

APR 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1926 to April 10, 1927.

that I last saw h[illegible] alive on April 10, 1927.

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis & insufficiency

Chronic interstitial nephritis

several years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. McP. Bacon, M. D.

4/11, 1927 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery DATE OF BURIAL 4/13 1927

20 UNDERTAKER: Chas F. Fraser & Son ADDRESS 1118 Mont Royal Ave

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21135 — 1a PLACE OF DEATH Mercy Hospital — 4-76 12 29 Edmond — REGISTERED No. E 21135

CITY OF BALTIMORE: (No. ____ ST., ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Galvin

(a) RESIDENCE No. 709 N. Fayette St. ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Don't know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Don't Know

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
48				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Don't Know

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Don't know

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Mercy Hospital (Address)

15 Filed APR 2 1927 C. HAMILTON JONES, M. D. Registrar. By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1927 to April 10, 1927.

that I last saw he alive on April 10, 1927

and that death occurred, on the date stated above, at 8 30 A. M.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis
Septicemia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) Rinaldo, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL April 12 1927

20 UNDERTAKER Charles F. Evans & Son — ADDRESS 1 E Mt Royal.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21136

CERTIFICATE OF DEATH.

E 21136

1-PLACE OF DEATH

City of BALTIMORE: (No. 2909 E. Baltimore St., V-7 Ward) 74-002

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Fitzberger

(a) Residence No. 2909 E. Baltimore St., Ward 1

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Christian H Fitzberger

6-DATE OF BIRTH (month, day and year) Oct 4th 1872

7-AGE. 54 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. George Bertsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14 (Informant) Christian Fitzberger

(Address) 2909 E Baltimore

15- Filed APR 2 1927 C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 10, 1927.

17- I HEREBY CERTIFY, That I attended deceased from Apr 1 1927 to Apr 10 1927 that I last saw h alive on Apr 10 1927 and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Embolism of cerebral artery

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Edward Keller M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount	April 13th 1927

20-UNDERTAKER.	ADDRESS
Frank V. Likitone	2515 E. Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

E 21137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO. E 21137

1-PLACE OF DEATH

City of BALTIMORE: (No.) 556 Presstman St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Day

(a) RESIDENCE NO. 556 Presstman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE: Years 42 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Stephen Day

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Lena Day

(Address) 556 Presstman St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1927, to Apr. 11, 1927,

that I last saw him alive on Apr. 10, 1927,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm J. Carr M. D.

Apr 12 27 (Address) 515 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Apr 12 27

20 UNDERTAKER: James L Wheeler — ADDRESS: Waddell

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21138 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 46 E 21138

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No.) 2811 Remington (St.) 12-51 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Dent.

(a) Residence No. 2811 Remington St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe | 4-COLOR OR RACE, Col | 5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Dent

6-DATE OF BIRTH (month, day and year) Aug. 26. 1889

7-AGE. 37 38 yrs. 7 mos. 13 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS

10-NAME OF FATHER Braxton Stokes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louise Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

11- (Informant) Charles Dent

(Address) 2811 Remington Ave

15- Filed ... 19.. Registrar. HAMILTON [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 9. 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1927 to Apr 9 1927

That I last saw h. alive on Apr 9 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Duration yrs. mos. ds

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 1926

Was there an autopsy? No

What test confirmed diagnosis? Pathological Exam

(Signed) B. Garland Abbott M.D.

Apr 12, 1927 (Address) 1534 Dulaney Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Rest Lawn Cem | DATE OF BURIAL Apr 11 19 27

20-UNDERTAKER Samuel Hardy | ADDRESS W. Baltimore St

Cor.—12-5-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21139

CERTIFICATE OF DEATH.

90 E 21139

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John Wesley Church, Sharp & Montgomery Sts. St. 17-23 Ward)

2-FULL NAME Sarah E. Moore. (C)

(a) RESIDENCE NO. 804 Harlen Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Widow.

5a If ~~married~~, widowed, ~~or divorced~~ (or) WIFE of Samuel Moore.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Barney Cassell (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Sarah Johnson. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Samuel R. Moore. (C) (son)

(Address) 804 Harlen Ave.

15 Filed APR 12 1927 19__ Registrar R H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner)

4/11 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Loud Auburn Lawn April 14 27

20 UNDERTAKER Edmund D. Brumley ADDRESS 578 W. Baltimore

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21140

CERTIFICATE OF DEATH.

46 E 21140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 N. Eutaw ST. 11-24 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Irvin

(a) RESIDENCE No. 1020 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) not known 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Private Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maurice Grigg

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Johnson — (Address) 1020 N. Eutaw St —

15 Filed ....., 19 . H. SAMUEL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 1927, to April 9th, 1927.

that I last saw her alive on April 9th, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Haemorrhage-Uterine

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Uterine Cancer — not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Samuel A Bair, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL April 18 27

20 UNDERTAKER Samuel A Ensley ADDRESS Baltimore

TION is very important. See instructions on back of certificate.

APR 12 1927

Spec.—1-12-23—M&T—500 Bks.

E 21141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21141

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Druid Hill Ave ST. 14-20 WARD)

2-FULL NAME Ethel V. Griggs

(a) RESIDENCE No. 1703 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

Female

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Wm B. Griggs

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Cato Md

PARENTS

10 NAME OF FATHER: James N. Pinson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary M. Stewart

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Va

14 Informant: Mary M. Pinson

(Address): 1706 Druid Hill Ave

15 Filed 19 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to April 9, 1927, that I last saw her alive on April 9, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs

Tuberculosis

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs complication of disease

(duration) yrs. 8 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) Dr G W Kennard, M. D.

4-10 1927 (Address) 708 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: April 12 27

UNDERTAKER: Samuel T Kinsley

ADDRESS: N Bel Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21142 1029 Madison Ave 46 E 21142

CERTIFICATE OF DEATH

Madison Ave. Hoffman

1-PLACE OF DEATH REGISTERED NO. 17-24

City of BALTIMORE: (No. Dr White Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laveina Cole

(a) RESIDENCE NO. 1N Little George St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Coles

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 41 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville Md

(State or country)

PARENTS

10 NAME OF FATHER John T. Smith

11 BIRTHPLACE OF FATHER (City or town) Howard Co. Md

(State or country)

12 MAIDEN NAME OF MOTHER Augustus Hardy

13 BIRTHPLACE OF MOTHER (City or town) Md

(State or country)

14 Informant Mrs Mary Diggs

(Address) 172 Elephant Rd.

15 Filed ..... 19 ..... FRANKLIN JONES, M. D. Registrar

Per .....

APR 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1927. to Apr. 11, 1927.

that I last saw her alive on Apr. 11, 1927.

and that death occurred, on the date stated above, at 10-45a m.

The CAUSE OF DEATH* was as follows:

Malegnant degenaration of

Fibroid of Uterus

(duration) Not known. yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr. 3, 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. White, M. D.

19 (Address) 1029 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem Date of Burial Apr. 14-27

20 UNDERTAKER Samuel Brinsley ADDRESS 1 W Balto

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21143

CERTIFICATE OF DEATH

E 21143

REGISTERED NO.

7-31 101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Bevans St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Spence

(a) RESIDENCE NO. 920 Bevans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 53 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bath Md

PARENTS

10 NAME OF FATHER: Nathaniel Mayfield

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Clarkson Bath Md

14 Informant: Lillie Palmer

(Address): 817 Warner St.

15 Filed 19 Registrar

Per

R 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 8, 1927, that I last saw h[illegible] alive on April 8, 1927, and that death occurred, on the date stated above, at 0 h. 50 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs Symptoms

(Signed) Charles H. Foster M. D.

April 1927 (Address) 7128 Bway. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Ft. Auburn Cem

Date of Burial: Apr 11 1927

20 UNDERTAKER: Samuel Hardy

ADDRESS: Fairfield

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21144 — 90 — E 21144

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1307 Argyle Ave St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A. Anderson

(a) RESIDENCE NO. 1307 Argyle Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Anderson

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 37 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter & Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer): Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm J. Anderson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Rush

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

14 Informant: Mamie Anderson (Address) 1307 Argyle Ave.

15 Filed ..... 19 .....

C. HAMPSON [illegible] Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 – 11. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1927, to April 10th, 1927, that I last saw h alive on April 10th, 1927, and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Val Dis of Heart (Mitral)

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) E. S. Walch, M. D.

. 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: 4/14/27

20 UNDERTAKER: Samuel K Hinds — ADDRESS: W Balto

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21145

CERTIFICATE OF DEATH.

E 21145

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 Fun St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H Ogden

(a) RESIDENCE NO. 1305 Main St Danville Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)
Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) Tobacco Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER John W. Ogden

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Alicia A. Gillett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Thomas Ogden
(Address) Elko Va.

15 Filed 19 C. HAMILTON JONES, M. D.
Registrar
For RM

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) 5 days

(Signed) Samuel H Ogden M. D.
(Coroner)

19 27 (Address) 3826 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Danville Va — Date of Burial 4/12 1927

20 UNDERTAKER Jos Grimsley — ADDRESS 112 E Balto St

Very important. See instructions on back of certificate.

APR 7 1927

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21146 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21146

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5304 Garrison ave St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle V Miller

(a) Residence No. 5304 Garrison ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John H Miller

6-DATE OF BIRTH (month, day and year) March 2 80

7-AGE.	If LESS than 1 day.
47 yrs. 1 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Wife

(b) General nature of Industry, business, or establishment in which employed (or employer): Home work

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Adam Kirk

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Susan Upton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) John H Miller

(Address) 5304 Garrison

15-Filed ..... 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10, 27

17- I HEREBY CERTIFY, That I attended deceased from 4-10 1927 to 4-10 1927

that I last saw h. alive on 4-10 1927

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

5 hrs.

(Duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home & Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Owen Dunnell M. D.

4-11-1927 (Address) 3902 Gardenia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Hill Cemetery — DATE OF BURIAL, April 13, 1927

20-UNDERTAKER, Wm Rountree — ADDRESS 2238 W Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21147

CERTIFICATE OF DEATH.

111-001

E 21147

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 23-31 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Bransby

(a) RESIDENCE NO. 19 W. Cross St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie H. Bransby

6 DATE OF BIRTH (month, day, and year) Sept 9/1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Bransby

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Bundy

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Annie H. Bransby

(Address) 19 W. Cross St

15 Filed....., 19..... C. H. [illegible] JONES M.D. Registrar

APR 12 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Hemorrhage Gastric Ulcer

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Jones M. D.

(Coroner)

4/12/27 (Address) 503 E. Noeth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial April 14 1927

20 UNDERTAKER F. A. Krause Co. ADDRESS 703 Hat...

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21148

CERTIFICATE OF DEATH.

X 101,001

E 21148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 25-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rae Mane Keefer

(a) RESIDENCE NO. Lansdowne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 11 1925

7 AGE: Years — Months 9 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): child

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Fred Keefer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bretonne sur

12 MAIDEN NAME OF MOTHER: Marie Poteet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bretonne sur

14 Informant: Fred Keefer

(Address) Lansdowne Rondelle Ave

15 Filed APR 12 1927 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/10, 1927, to 4/11, 1927, that I last saw h[illegible] alive on 4-11, 1927, and that death occurred, on the date stated above, at 12 50 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, involvement both lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jotheron Stuler M. D.

(Address) 4/11, 1927 St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL: Apr 13 1927

20 UNDERTAKER: Jos Joesdens & Son

ADDRESS: 2175 Rec

Cor.—12-9-25—A Co.—200 Bks.

Weber

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21149

REGISTERED NO. 90 E 21149

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

E 21149

1-PLACE OF DEATH

City of BALTIMORE: (No. Insanity Hosp St. 18-26 Ward)

2-FULL NAME Anna Weber

(a) RESIDENCE NO. 131 Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Weber

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 43; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country)

PARENTS

10 NAME OF FATHER: Martin Zelenska

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Standart

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Albert Weber

(Address) 131 S Appleton St

15 Filed APR 12 1927

16 C. HARRISON JONES, M. D.

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurg

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dennis F. Cushing M. D.

(Coroner)

19 27 (Address) 3328 Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Date of Burial: Apr 11 1927

20 UNDERTAKER: H. C. Brauning & Son

ADDRESS 517 N. Schroeder

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21150

CERTIFICATE OF DEATH.

117 E 21150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospital St. 11-24 Ward)

2-FULL NAME Harry Wilson

(a) RESIDENCE NO. 923 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 30 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elizbeth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Mary Dixon
(Address) 923 Linden ave.

15 Filed 192[illegible] Registrar

OCT 17 1927 JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 27 19

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1927 to April 10, 1927

that I last saw him alive on April 10, 1927

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Epidermoid Cancer
of Scrotum

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Oesophagus Stenosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Mar. 20, 27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 4/13 1927

20 UNDERTAKER: Edwin A. Cole — ADDRESS 1-12 Dolphin

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 21151

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

E 21151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 West Fayette St. 18-76 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary May

(a) RESIDENCE NO. 1000 West Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. May

6 DATE OF BIRTH (month, day, and year) December, 3rd 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	44	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer At home

9 BIRTHPLACE (rity or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Hoffman

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Kaiser

13 BIRTHPLACE OF MOTHER (rity nr town) Baltimore

(State or country) Maryland

14 Informant George T. May

(Address) 1000 West Fayette St.

15 Filed APR 12 1927, 19 C. HARRISON JONES, M. D. Registrar

Per

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) April, 11th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Apr 12, 1927, that I last saw h[illegible] alive on Mch 9, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension.

(duration) four yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Barnard Hood, M. D.

4/12. 1927 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

Date of Burial Apr. 13th 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Calvert St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 21152

E 21152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square 19-26

CITY OF BALTIMORE; (No. F. S. H. ST., WARD)

2-FULL NAME Master Amon Shifley

(a) RESIDENCE NO. Owings Mill Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29th 1910.

7 AGE: Years 12 | Months 2 | Days 13 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Md

PARENTS

10 NAME OF FATHER Jarel Shifley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Arabelia Chrismore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Josh Shifley Owings Mills Md

15 Filed APR 12 1927 Past

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927. to April 11, 1927.

that I last saw h[illegible] alive on April 10, 1927.

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows

Bronchio-Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Hepatitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Wallace Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL: April 13th 27

20 UNDERTAKER: J. F. Cline & Sons ADDRESS: Reisterstown

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21153

CERTIFICATE OF DEATH

101-801

E 21153

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 718 School St 14-20 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Barker.

(a) RESIDENCE NO. 718 School St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored Single

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21st 1923

7 AGE: Years 3 Months 5 Days 10 21

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Joseph Barker

11 BIRTHPLACE OF FATHER (City or town) St Marys Co

(State or country)

12 MAIDEN NAME OF MOTHER Sadie Gardner

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant Joseph Barker

(Address) 718 E School St

15 Filed APR 21 1927 19 C. HARRISON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/11 1927 to 4/12 1927

that I last saw h[illegible] alive on 4/11 1927

and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm R Watts M. D.

4/12 1927 (Address) City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial April 25 27

20 UNDERTAKER Clarence E Wright ADDRESS 364 W Lanvale

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21154

CERTIFICATE OF DEATH.

90 E 21154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 Belgian Ave St. 27-47 Ward)

2-FULL NAME Thos. J. Conway

(a) RESIDENCE NO. 717 Belgian Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1850

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Hotel

(b) General nature of industry, business, or establishment in which employed (or employer) Manager

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Conway

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Millard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mary Griffin

(Address) 1305 Harford Ave

15 Filed 4/12/27 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Price M. D.

(Coroner)

4/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Loudon Park Cemetery 19

20 UNDERTAKER ADDRESS

Joseph L. Moran 5002 Eastern Ave.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21155

CERTIFICATE OF DEATH.

31 E 21155

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 131 E Hughes St. Ward) 22-33

2-FULL NAME Anna L. McKeever

(a) RESIDENCE NO. 131 E. Hughes St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) —/1893

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. L. McKeever

11 BIRTHPLACE OF FATHER (city or town) Ga.

(State or country)

12 MAIDEN NAME OF MOTHER Anna Wolf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Wm. L. McKeever

(Address) 131 E Hughes St.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from January, 19 27, to April 10, 19 27,

that I last saw h... alive on April 1, 19 27,

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

April 11, 19 27 (Address) 131 E. Hughes St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

Date of Burial 4/13 19 27

20 UNDERTAKER J. T. Talbert Sons

ADDRESS 314 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21156 E 21156

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2260 Morris St ST., 13-59 WARD)

2-FULL NAME Estisher Green

(a) RESIDENCE NO. 2260 Morris St ST., WARD Sumter S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edmon Green

6 DATE OF BIRTH (month, day, and year) May 15, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sumter Co South Carolina

PARENTS

10 NAME OF FATHER Click Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sallie Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Edmon Green Sumter S.C.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to April 10, 1927, that I last saw her alive on April 10, 1927, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Carcinoma of Breast (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? S. C.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) Dr. W. Kennard M. D.

4 11. 1927 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bishopville S.C.

DATE OF BURIAL April 12 1927.

20 UNDERTAKER Thomas E. Kelan

ADDRESS 1510 Preastman St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21157

CERTIFICATE OF DEATH

52 E 21157

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 8023 Fourth St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Sevcik

(a) RESIDENCE NO. 8023 S. 4th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Joseph Sevcik

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Sluvice,

(State or country) Austria, Hungary

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) Sluvice

(State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Sluvice

(State or country) Austria Hungary

14 Informant Joseph Sevcik Jr.

(Address) 8023 S. 4th St.

15 Filed 12 1927 C. H. MASON JONES, M. D. Registrar

Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5 1927 to April 11 1927

that I last saw h er alive on April 7 1927

and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows: Chronic Arthritis

(duration) 25 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Joseph Taubes, M. D.

. 19 (Address) 804 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

Date of Burial April 19 27

20 UNDERTAKER Grand Cross Funeral

ADDRESS Baltimore Md

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21158

101-001

E 21158

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3105 O'Donnell St. St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Burkle

(a) RESIDENCE NO. 3105 O'Donnell. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Burkle.

6 DATE OF BIRTH (month, day, and year) Dec. 22–1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	36	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Standard. Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Louisville

(State or country) Ky.

PARENTS

10 NAME OF FATHER John Burkle.

11 BIRTHPLACE OF FATHER (City or town) Louisville

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Murphy.

13 BIRTHPLACE OF MOTHER (city or town) Louisville

(State or country) Kentucky

14 Informant Edith Burkle.

(Address) 3105 O'Donnell St.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12–1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 9, 19 27, to April 12, 19 27,

that I last saw him alive on April 11, 19 27,

and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas M. D.

4-12 19 27 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louisville Cave Hill Cem., Ky. Date of Burial April 12th 1927

20 UNDERTAKER Lilly & Zeller ADDRESS 903 S. Wolfe St.

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21159

CERTIFICATE OF DEATH.

Registered No. 89

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 Harford Ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Bell Suehle

(a) Residence No. 2216 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced. (~~Write the word.~~) Divorced

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John and Suehle

6-DATE OF BIRTH (month, day and year) July 12-1865

7-AGE. 61 24

62 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). Housewife

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Henry Medinger

11-BIRTHPLACE OF FATHER (city or town). Balto. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mamie Medinger

13-BIRTHPLACE OF MOTHER (city or town). Balto. (State or Country). Md.

14- (Informant) Husband - Suehle

(Address) 2216 Harford Ave

15- Filed APR 14 1927 C. HAMPSON JONES, M. D. Registrar. Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 14 1927

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 14, 1927, that I last saw h. ~~alive~~ on April 10, 1927 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert G. Singmaster M. D.

4/16/ 1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cem. DATE OF BURIAL. April 13 1927

20-UNDERTAKER. Wm. H. Valentine ADDRESS 2224 Aisquith St.

Spec.—1-10-21—M&T—1500 Bks.

21160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66

E 21160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 Lemmon ST. 20-64 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Indres

(a) RESIDENCE NO. 2502 McHenry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	not Known		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant M. Indres

(Address) 2502 Mc Henry St

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1927, to April 11, 1927, that I last saw h[im] alive on April 10, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A V Buchuelos M. D.

4/12, 1927 (Address) 37 S. Strieker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 13 '27

20 UNDERTAKER John Grabbianchan — ADDRESS 423. S. Paca St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21161 E 21161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 W. Cross St., 21-29 WARD)

REGISTERED NO. 161-1927

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H Miller

(a) RESIDENCE NO. 1132 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Apr 4. 1927

7 AGE: Years | Months | Days: 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Charles A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Jessie J. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Charles A. Miller

(Address): 1132 W. Cross St.

25 2 1927 C. HAMPSON JONES, M. D. Registrar

Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1927 to Apr 12 1927

that I last saw h[illegible] alive on Apr 12 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Schwarzenberg M.D.

1929 (Address) 1132 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Apr 13 1927

20 UNDERTAKER: Mr & Mrs J W Turpel & Son

ADDRESS: 601 W Lafayette

HON is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21162

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 E. 20th St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Harkins

(a) RESIDENCE NO. 1026 E. 20th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Southworth Harkins

6 DATE OF BIRTH (month, day, and year) Jan 29/1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer L. Kirshen

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Harkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Boyle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Viola S. Harkins

(Address) 1026 E 20th St

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Odema-Probably Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Butler M. D.

(Coroner)

4/11/27 (Address) 50 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 4/14/27 19

20 UNDERTAKER Mary M. Wiedefeld ADDRESS 50 E. 22 St.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21163

CERTIFICATE OF DEATH.

91-002

E 21163

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 N. East ave. St. 6-11 Ward)

2-FULL NAME Benjamin F. Urey

(a) RESIDENCE NO. 424 N. East Av. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L. Urey

6 DATE OF BIRTH (month, day, and year) Dec. 16th, 1848

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	78	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) (R)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Pa.

PARENTS

10 NAME OF FATHER George Urey

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Zehner

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Pa.

14 Informant Mrs. Chester Shimp

(Address) 424 N. East ave.

15 Filed _____ C. HAMPSON JONES, M. D. Registrar

1927 Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 27 1926, to Apr 10 1927, that I last saw h.... alive on Apr 10 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Gangrene L. Fot

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Senile Sclerosis

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) _____, M. D.

4/12 1927 (Address) 301 S Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster, Pa. Date of Burial 4/13 1927

20 UNDERTAKER E. D. Cunningham 1938 E. Lafayette ave. ADDRESS

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21164

CERTIFICATE OF DEATH.

21-29

E 21164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1003 Burgundy St., ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin W. Knapp.

(a) RESIDENCE NO. 1003 Burgundy St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin F. Knapp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Easter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Catherine Knapp,
(Address) 1003 Burgundy St.

15 Filed APR 13 1927 19 WILLIAM H. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1927.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 9- 1927. to Apr. 11 1927.

that I last saw him alive on Apr. 10 1927

and that death occurred, on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? NO Date of --

Was there an autopsy? - NO -

What test confirmed diagnosis? Clinical

(Signed) H. G. Friedinger M.D. M. D.

4/12 1927 (Address) 682 North Blvd -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 4/13 1927

20 UNDERTAKER Harry L Wetzler

ADDRESS 1[illegible] Linden Ave.

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 21165

CERTIFICATE OF DEATH.

E 21165

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto city Home 14-26 Ward)

2-FULL NAME Edward Eisenberg

(a) RESIDENCE NO. 234 North Carey st. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: 70; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): maryland

(State or country)

PARENTS

10 NAME OF FATHER: John Eisenberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Holland

12 MAIDEN NAME OF MOTHER: Mary R

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Holland

14 Informant: Hospital Record

(Address)

15 Filed APR 13 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11-1927 19

17 I HEREBY CERTIFY, That I attended deceased from 1-7-'27 to 4-11-'27, 19

that I last saw him alive on 4-11-'27, 19

and that death occurred, on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma Rectum

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Liver Metastasis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 7'26

Was there an autopsy? no

What test confirmed diagnosis? Phy findings

(Signed) Em Eckstein, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: April 13 1927

20 UNDERTAKER: Harry H Ketzke — ADDRESS: 1516 Lombard st

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21166

CERTIFICATE OF DEATH.

E 21166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 Wilkens Ave St. 20-72 WARD)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma May Bowers

(a) RESIDENCE NO. 2707 Wilkens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) 4-4-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Verna Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Fred Bowers (Address) 207 Wilkens Ave

15 Filed APR 13 1927 [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-4 1927 to 4-11 1927

that I last saw her alive on 4-11 1927

and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eva F. Dodge M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL April 13 1927

20 UNDERTAKER Harry H. Nolte

ADDRESS Harry H. Nolte

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21167 — 1-01-001 — E 21167

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST., 20-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME D. Herbert Yost

(a) RESIDENCE NO. 2518 N. Bath ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND (~~or WIFE~~) of: Anna (Lindenmuyer)

6 DATE OF BIRTH (month, day, and year): April 21 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~or~~	41	11	20	

8 OCCUPATION OF DECEASED: Foreman

(a) Trade, profession or particular kind of work: 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Jonathan I. Yost.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Catherine A. Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Jonathan I. Yost

(Address): Lochiel Manor Shermessing Pa

15 Filed APR 13 1927, 19 Per ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1927. to April 11, 1927.

that I last saw h~~er~~is alive on April 11, 1927.

and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

Non-epidemic

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Walker, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tamaqua Pa.

DATE OF BURIAL: April 17 1927

20 UNDERTAKER: Harry A. Hetzke

ADDRESS 1531 N Smallwood St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21163

E 21168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 12 N. Bond St St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Spriggs

(a) RESIDENCE NO. 12 N. Bond St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) July 20/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Bardnard Spriggs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Sarah Williams

(Address) 119 S. Bond St

Filed APR 13 1927 19____ C. HAWKEY JONES, M. D. Registrar

Per K. H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prob by Bronchopneumonia (Primary).

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Williams M. D.

(Coroner)

4/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial April 19, 27

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21169

CERTIFICATE OF DEATH.

101-201

E 21169

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence Strickland

(a) RESIDENCE NO. 613 N. Spring St. Balto Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
~~Female~~	Col	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-16-1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2 yrs	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Strickland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Bessie Goff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed ..... 1927 H. Bond Jones M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Apr. 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 7, 1927, to Apr 10, 1927, that I last saw him alive on Apr 10, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray

(Signed) I. Ridgeway Thomas, M. D.

, 19 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemety — Date of Burial: April 19 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 691 orleans st

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1968

E 21170

101-001

CERTIFICATE OF DEATH.

E 21170

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. HNS HOPKINS HOSPITAL St. 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Sewell

(a) RESIDENCE NO. 1606 Mulligan St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: | Months: 8 | Days: | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER: Fred Sewell

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Sewell

13 BIRTHPLACE OF MOTHER (city or town): Md —

(State or country)

14 Informant: Records —

(Address) HNS HOPKINS HOSPITAL

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7 1927 to Apr. 11, 1927, that I last saw h.. alive on Apr 11, 1927, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) J. Ridgeway Schmidtz, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sural cemetery — Date of Burial: April 14, 27

20 UNDERTAKER: Edward C Orson — ADDRESS: 691 Orleans St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

CERTIFICATE OF DEATH.

E 21171

REGISTERED NO. E 21171

1-PLACE OF DEATH

City of BALTIMORE: (No. 627 N. Luzerne St., 711 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tillman

(a) RESIDENCE NO. 627 N. Luzerne St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Austria

(State or country)

PARENTS

10 NAME OF FATHER Frank Rehounck

11 BIRTHPLACE OF FATHER (city or town) Austria

(State or country)

12 MAIDEN NAME OF MOTHER Kath. Kucera

13 BIRTHPLACE OF MOTHER (city or town) Austria

(State or country)

14 Informant: Matilda Bradley

(Address) 627 N. Luzerne

Filed APR 13 1927 HAMPSON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 11th

17 I HEREBY CERTIFY, That I attended deceased from Apr 26 1926, to Apr 11 1927,

that I last saw h[illegible] alive on April 11, 1927,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

General Metastasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(Duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. H. Meyer Jr., M. D.

4/11, 1927 (Address) 1500 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. Date of Burial: April 14 1927

20 UNDERTAKER: Geo. L. Klein & Son ADDRESS 156 N. Luzerne

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Carter St St. 12-19 WARD)

2-FULL NAME Mary E. Taylor

(a) RESIDENCE No. 1706 Carter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	B	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of George Taylor (dec)

6 DATE OF BIRTH (month, day, and year) Autumn 885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	42	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Cook.

(c) Name of employer Eudowood Hospital Md.

9 BIRTHPLACE (city or town) (State or country) Towson Md.

PARENTS

10 NAME OF FATHER Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Twickley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bonnie Brown (Address) 1706 Carter St

15 Filed 4-13, 19 27 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to April 10, 1927.

that I last saw h. W alive on April 10, 1927.

and that death occurred, on the date stated above, at 2, 35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

4/10, 1927 (Address) 733 Arguith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Rest Towson Md.	4-13 1927
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Druid Hill

HON IS VERY important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21173

CERTIFICATE OF DEATH

E 21173

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 3703 Hickory Ave Ward 43-57)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L Wilhelm

(a) RESIDENCE NO. 3703 Hickory Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 ~~Single, Married~~ Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W Wilhelm

6 DATE OF BIRTH (month, day, and year): Aug 15 1848

7 AGE: 78 Years 7 Months 26 Days. If LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant C. O Wilhelm

(Address) ~~3703 Hickory Ave~~

15 Filed APR 13 1927 C. HAMPSON JONES, M. D., Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to April 11, 1927

that I last saw her alive on April 11, 1927

and that death occurred, on the date stated above, at 1035 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. 11 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. O Wilhelm M. D.

4-12, 1927 (Address) 3701 Richard Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

Date of Burial Apl 14 1927

20 UNDERTAKER Chenowith & Son

ADDRESS 360 Chestnut Ave

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21174

CERTIFICATE OF DEATH

E 21174

REGISTERED NO. 161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 N Green St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Calamisi

(a) RESIDENCE NO. 409 N Green St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12-1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Rasoris Calamisi

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Isabella Encoprsa

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Rasoso Calamisi

(Address) 409 N Green St

15 Filed APR 13 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-11-27

17 I HEREBY CERTIFY, That I attended deceased from 2-20-, 1927, to 4-11-, 1927, that I last saw her alive on 4-11, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia.

Emphysema -

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Acute myocarditis.

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? 3-25-27

Did an operation precede death? yes Date of 4-10-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Observation

(Signed) S. Swarts, M. D.

4-12, 1927 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial 4-13-1927

20 UNDERTAKER Robt Brooks & Son — ADDRESS Calhoun Hollins

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

E 21175

CERTIFICATE OF DEATH.

E 21175

REGISTERED No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Goldfarb.

(a) RESIDENCE NO. 1040 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred W yrs. mos. ds. How long in U. S., if of foreign birth? W yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Goldfarb

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lace Trader

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Sam. Goldfarb

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Ella —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sdg. Goldfarb

(Address) 1040 Lombard

15 Filed PRT 3 1927 C. HAMPSON JONES, M. D. Per R.K. Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an On Enq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) (Coroner) M. D.

Apr. 12, 1927 (Address) 1632 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial 4/13 1927

20 UNDERTAKER Jack Levis ADDRESS 1439 E. Balt St

Spec.–7-17-26—A Co.—200 Bks.

E 21176

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21176

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp REGISTERED NO.

City of BALTIMORE: (No. St. 12-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. A. B. Mc. Cleary

(a) RESIDENCE NO. Waynesboro. Pa St. R.F.D. #1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 4. 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
41	41	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa

PARENTS

10 NAME OF FATHER Harry Mc. Cleary

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER Alice Mack

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Hospital Records

(Address)

15 Filed APR 13 1927 C. HAMPSON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4 – 12 – 27

17 I HEREBY CERTIFY, That I attended deceased from 3 – 21, 1927, to 4-12, 1927, that I last saw h alive on 4 – 12, 1927, and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH* was as follows:

1 Hypernephroma – Kidney left

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 4-8-27

Was there an autopsy? no

What test confirmed diagnosis? Examination of pt.

(Signed) R. D. Belford M. D.

. 19 (Address) Union memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro Pa

Date of Burial Apr 13 1927

20 UNDERTAKER C. J. Barton

ADDRESS 5 W Main Street Waynesboro

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-02

E 21177 **E 21177**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 E Fort Ave St. 24-34 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Neuhauser

(a) RESIDENCE NO. 317 E Fort Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 4.12.1927

7 AGE: Years 45 Minutes Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John L. Neuhauser

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hitzelberger

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Mrs Mary R Neuhauser

(Address) 317 E Fort Ave

15 Filed APR 13 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 4.12

17 I HEREBY CERTIFY, That I attended deceased from 4.12, 1927, to 4.12, 1927, that I last saw h[illegible] alive on 4.12, 1927, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Diptheria. R.O.F.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza 45 Minutes

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis!

(Signed) L J Surlington, M. D.

4.12.1927 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemtry Date of Burial April 14 1927

20 UNDERTAKER Fred. A. Weusers ADDRESS 783 Hanover

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21178

CERTIFICATE OF DEATH.

36-42

94-001

E 21178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hazelwood & Cole Ave ST. WARD)

2-FULL NAME Henry Appler

(a) RESIDENCE NO. Hazelwood & Cole Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	81	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Appler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur P. Appler

(Address) Hazelwood & Cole Ave

15 Filed 4/13, 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927 to April 11, 1927.

that I last saw him alive on April 11, 1927

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mc Goode M. D.

4/12, 1927 (Address) 108 N. Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL April 14 1927

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21179 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 E 21179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. 10 WARD)

2-FULL NAME Michael Hester

(a) RESIDENCE NO. St. Vincent's Infant Asyl. - 1401 Division St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6. 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mary E. Hester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Hester

(Address) St. Vincents - Division St

Filed 4-13-1927, 19 C. HAMILTON JONES, M. D. Registrar

Per K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to April 13, 1927, that I last saw h[illegible]alive on April 13, 1927, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

4/13, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 4-13-27

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 North Ave W

Spec.–7-17-26—A Co.—200 Bks.

E 21180

HEALTH DEPARTMENT—CITY OF BALTIMORE

31.

CERTIFICATE OF DEATH

E 21180

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1324 N Strieker St. 15-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jaskins

(a) RESIDENCE NO. 1324 N Strieker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Jaskins

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 46 Months Days IF LESS than 1 day. hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Northumberland Co. Va

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Delia A. Lewis

(Address) 1324 N. Strieker St.

15 Filed APR 13 1927 By C. HAMPSON JONES, M. D. Registrar Per RAL

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-11-1927

17 I HEREBY CERTIFY, That I attended deceased from 11-10-, 1926, to 4-11-, 1927, that I last saw h[illegible] alive on 4-10-, 1927, and that death occurred, on the date stated above, at 9:[illegible] A.m.

The CAUSE OF DEATH* was as follows:

Nephritis

Le 11 26

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Diabetes & Influenza

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank A. Saunders, M. D.

, 19 (Address) 1324 Strieker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnson Northumberland Co Va

Date of Burial: April 1927

20 UNDERTAKER: Mrs H. Elliott

ADDRESS: Ashland

Spec.—12-9-25—A Co.—200 Bks.

Scrodover.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21181

CERTIFICATE OF DEATH.

129

E 21181

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital, 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Scrodover

(a) RESIDENCE NO. Sinai Old Folks Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Boston

(State or country): Eng.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Hosp. Records

(Address): Sinai Hosp.

FILED APR 13 1927 C. HARRISON JONES, M. D. Registrar

Per R.M.

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/13/ 1927, to 4-12 1927,

that I last saw her alive on 4-12 1927,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - sclerosis

Cardiac Hypertrophy & Dilatation

Chronic Nephritis ?

(duration) yrs. mos. ds.

CONTRIBITORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clin. Signs + Symp

(Signed) C. Victor Jacobs, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cit. Cemetery Hebrew Washington Rd. Date of Burial 4/13/1927

20 UNDERTAKER: Harry Londheim ADDRESS 116 & 118 W. Fayette & Royal Av.

Spec.—1-12-23—M&T—500 Bks.

(Seropotis)

D. 21182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 21182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Mary's Hospital 2-4 WARD)

REGISTERED NO. 190

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Seropolis

(a) RESIDENCE NO. 1712 Thames Street ST. Steamship Western Plains WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) S/S "Western Plains"

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Christopholus Seropolis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER — Kaliopen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grace

14 Informant Hospital Records (Address)

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Reg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to April 13, 1927, that I last saw him alive on April 13, 1927, and that death occurred, on the date stated above, at 12 29 A. m.

The CAUSE OF DEATH* was as follows:

Tumor of Mediastinum (type undetermined)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & Laboratory tests

(Signed) Otto Beutow, M. D.
A.A. Surgeon, U.S.P.H.S.

4/13, 1927 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL April 14 1927

20 UNDERTAKER George F. Ruth

ADDRESS 1735 Harford Ave.

Spec.—12-5-25—A Co.—200 Bks.

E 21183

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21183

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 8-13 Ward)

2-FULL NAME Emil Komenda

(a) RESIDENCE NO. 1609 Faith Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Komenda

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Vernica Komenda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Hospital Records

(Address)

15 Filed 3-7-1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1926, to April 11, 1927, that I last saw him alive on April 11, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Cons. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gatlenk, M. D.

4-14-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery Date of Burial Apr 14 27

20 UNDERTAKER Fahrney Bros ADDRESS 1562 N Gay.

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21184

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 438 S. Parrish St., 19-28 Ward)

2-FULL NAME... Amelia Brogan

(a) Residence No. 438 S. Parrish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write this word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Benjamin Brogan

6-DATE OF BIRTH (month, day and year) July 21 1856

7-AGE 70 yrs. 8 mos. 21 ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Annie Scheffel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Benjamin Brogan

(Address) 438 S. Parrish St.

15- (Filed) 1927 (Registered) C. HEMPSON JONES, M. D.

By

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 12, 1927

17- I HEREBY CERTIFY, That I attended deceased from March 7 1927 to April 12 1927

that I last saw her alive on April 11 1927

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

Probable

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 438 S. Parrish

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) C. L. Nuckols M. D.

19 (Address) 130 S. Gilmor St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, April 15 1927

20-UNDERTAKER, Thos. J. Fields — ADDRESS 1200 N. Fremont

instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21185

E 21185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. INS HOPKINS HOSPITAL, Ward) 20-27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. 562 Bruce St. Balto Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-28-27

7 AGE: Years 10 days | Months 0 | Days 11 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Gladys Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) INS HOPKINS HOSPITAL

15 Filed APR 12 1927 C. HAMPSON JONES, M. D.

Per 1217 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9 April 1927

17 I HEREBY CERTIFY, That I attended deceased from 31 March, 1927, to 9 Apr, 1927, that I last saw h~~im~~ alive on 9 Apr, 1927, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Handley, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL APR 12 1927

20 UNDERTAKER — ADDRESS

Commissioner Health.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21186 E 21186

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1212 Chatham St. 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Persons

(a) RESIDENCE NO. 1212 Chatham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 4. 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Julia Persons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant

(Address)

15 Filed 1 3 1927 C. HAMPSON JONES, M. D. Registrar

Per 1250

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to April 11, 1927, that I last saw h— alive on April 11, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Benny, M. D.

, 19 (Address) 1502 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

Feb 13 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21187 ✓ 161-001 E 21187

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 East St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 16 East St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1927

7 AGE Years Months Days: 4

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Julius Smith

11 BIRTHPLACE OF FATHER (City or town) B C

(State or country)

12 MAIDEN NAME OF MOTHER Lucinda Slate

13 BIRTHPLACE OF MOTHER (city or town) B C

(State or country)

14 Informant .....

(Address) .....

15 Filed ..... 19 ..... Registrar

1249 Per .....

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927, to April 12, 1927

that I last saw h[illegible] alive on April 11, 1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Congenital Abnormality

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 5 Gottlieb M. D.

(Address) 08 Bonsent St

4-12 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

Date of Burial: Apr 12 1927

20 UNDERTAKER: C. HAMPSON JONES M. D. Commissioner Health

ADDRESS

Per Wm. E. WOODALL

1249 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21188 31 E 21188

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 410 S Bethel St St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Lipinska

(a) RESIDENCE NO. 410 S Bethel St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 31 Months Days IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Mary Wiecorek

(Address) 1628 eastern ave

15 Filed 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 12 27

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1927 to April 10, 1927

that I last saw her alive on April 10, 1927

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Kruger, M. D.

, 19 (Address) 2622 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary cem Date of Burial April 13 1927

20 UNDERTAKER: John McNeley ADDRESS 1803 Bank St

Fill in all items, if any, about which inquiry is made. See instructions on back of certificates. very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 E 21189

REGISTERED NO. E 21189

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1524 Linden Ave. (Ward) 14-20

2-FULL NAME Mrs. Sophia Ann Wilson

(a) RESIDENCE NO. 1524 Linden Avenue Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, ~~or divorced~~ (or) WIFE of Samuel A. Wilson

6 DATE OF BIRTH (month, day, and year) October-16-1838

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	88	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER William H. Stansbury

11 BIRTHPLACE OF FATHER (city or town) Bata Co

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elenora Safford.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Miss Wilson (daughter)

(Address) 1524 Linden Ave

13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1927 to April 12 1927,

that I last saw her alive on April 12 1927, at 4:35 a. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypostatic Pneumonia

Syphilis, chronic. ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Henry S. S. Wilson, A. M., M. D.

, 19 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial April 15 1927

ADDRESS

20 UNDERTAKER Ingles & Jones 1 E Preston & N Broadway

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21190

CERTIFICATE OF DEATH.

31 E 21190

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: Left Arch St. 4-16 Ward)

2-FULL NAME William H. Rattigan

(a) RESIDENCE NO. 123 N Fremont St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie McLaughlin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

10 NAME OF FATHER Wm. H. Rattigan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ella Burns

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

PARENTS

14 Informant Mary A. Jones

(Address) 123 N. Fremont Ave

Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. TB.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) G C Hades M. D.

(Coroner)

Apr 12 1927 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Date of Burial 4/14 1927

20 UNDERTAKER John J. Cowan & Son ADDRESS 901 Hollins St

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21191 ✓ 84 E 21191

CERTIFICATE OF DEATH

REGISTERED NO. 15-58

1-PLACE OF DEATH

City of BALTIMORE: (No. Sollings Sanatorium Norwood Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Steele

(a) RESIDENCE NO. 3606 Reisterstown Road. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24th. 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	48	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Steele

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Clara Brandt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Irving L. Steele

(Address) Majestic Apts. 1 C.

15 Filed 4/13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from March. 10, 1927 to Apr. 10, 1927

that I last saw h[illegible] alive on Apr. 10, 1927

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Epilepsy -

(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Contusion of

(duration) 0 yrs. 0 mos. 12 ds.

18 Where was disease contracted? Hospital (Boticine)

If not at place of death? Institution from (Fracture)

Did an operation precede death? N.O. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/13 1927 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cheb Shalom Cemetery — Date of Burial: 4/15/ 1927

20 UNDERTAKER: David Sondheim — ADDRESS: 1820 W. Mt. Royal Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21192

179 E 21192

CERTIFICATE OF DEATH.

REGISTERED NO. _____

1-PLACE OF DEATH South Baltimore Gen Hosp

City of BALTIMORE: (No. 24-33 St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Santmyer

(a) RESIDENCE NO. 109 Riverside Ave St. 14 Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Santmyer.

6 DATE OF BIRTH (month, day, and year) Dec 16, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Pulaski Realty Co

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER John Santmyer

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Emma Long

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs Santmyer

(Address) 109 Riverside Ave

Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Par _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-27 19

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1927, to 4-13, 1927, that I last saw h. alive on 4-12, 1927, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Myocardial failure

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cystitis, Pyuria & Pyelitis, Hypostatic Pneumonia, both lungs

(duration) yrs. mos. 5 ds.

18 Where was disease contracted at work

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Strauss, M. D.

, 19 (Address) S. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

Date of Burial 4/15 1927

20 UNDERTAKER J. F. Lahey & Sons

ADDRESS 1318 Light St.

very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21193
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 21193

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1501 Mt. Royal Ave., ST., 14-20 WARD)

2-FULL NAME Lawrence Sangston Gwyn

(a) RESIDENCE No. 1501 Mt. Royal Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sue Gwyn

6 DATE OF BIRTH (month, day, and year) Oct. 25th. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
63	62	5	20	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John T. Gwyn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Carey Thruston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lawrence S. Gwyn, Jr
(Address) 1501 Mt. Royal Ave.

15 Filed APR 14 1927 C. HAMPSON JONES, M. D. Registrar
By RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to April 12, 1927, that I last saw him alive on April 12, 1927, and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Mitral Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Typical findings.

(Signed) W. H. Fowler M. D.

19 (Address) 1408 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Apr. 14 1927

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison

ATION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21194

CERTIFICATE OF DEATH.

×44 E 21194

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) ST. 4-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Brent Matthews

(a) RESIDENCE NO. La Plata Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Religious

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min
63	2	10 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Victoria Brent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Brooke Matthews

(Address) La Plata, Md.

15 Filed APR 14 1927 H. M. JONES, M. D. Registrar

16 by ---

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to April 13, 1927, that I last saw h alive on April 13, 1927, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ? stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? Date of Dec 13-1926

Was there an autopsy? ---

What test confirmed diagnosis? Clinical

(Signed) ---, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL La Plata, Md.

DATE OF BURIAL 4/14 1927

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

To via automobile

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21195

CERTIFICATE OF DEATH.

24-34 1927

E 21195

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Miller.(C)

(a) RESIDENCE NO. 606 Meyers Court. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of indusiry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Mazie Burgess.(C)

(Address) 606 Meyers Court.

15 Filed APR 14 1927, 19 C. H. WILSON JONES, M. D. Registrar

Per KJC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage due to a fracture of the skull. Struck on the head by a gate hinge. Homicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Hall Leonhardt M. D. (Coroner)

4/12 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? Meyers Court & York St. Oct. 9, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct. Date of Burial April 19 1927

20 UNDERTAKER C. H. Brown & Son ADDRESS 1911 Madison Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Susan J. Heshill

E 21196 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21196

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1617 Penn ave (St.) 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan J. Heshill

(a) RESIDENCE NO. 1617 Penn Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years 64 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) White Hall Md

PARENTS

10 NAME OF FATHER John Heshill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Harford

12 MAIDEN NAME OF MOTHER Betsy Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Washington Coleman (Address) 1617 Penn ave

15 Filed APR 14 1927 19 Per RM Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6th 1927 to April 11th 1927 that I last saw h— alive on April 10th 1927 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Hard Coughing Woman only

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed A. Lee Ellis, M. D.

1927 (Address) 1624 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Haven Md DATE OF BURIAL 4/14/27

UNDERTAKER Samuel Hawley ADDRESS 2136 Ell

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-003

E 21197

CERTIFICATE OF DEATH.

E 21197

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 12-B-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Trice

(a) RESIDENCE NO. 1802 Maryland ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Trice

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Susie Cummins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed APR 14 1927 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 19 26, to April 12, 19 27,

that I last saw h... in alive on April 12, 19 27,

and that death occurred, on the date stated above, at 7 a. m.

THE CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous lympho-adenitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Gatewood, M. D.

4-12-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial Apr 15 27

20 UNDERTAKER Samuel T. Hawley — ADDRESS 578 N. Eutaw

very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21198

CERTIFICATE OF DEATH.

100-001

E 21198

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 439 S. Gilmor St. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward L. Bafford. Jr.

(Residence in Baltimore: No. 439 S. Gilmor St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: March 21st, 1927 (Month) (Day) (Year)

7-AGE: ..... yrs. 22 mos. 23 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Edward L. Bafford Sr.

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Margorie Buchanan

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mr. Edward L. Bafford

(Address): 439 S. Gilmor St

15- C. HAMPSON JONES, M. D.

Filed ..... 191.....

APR 15 1927 Per ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: April 13., 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 9 1927, to Apr. 13. 1927, that I saw him alive on Apr. 13. 1927, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Hampson Jones, M. D.

4/14/27 191... (Address) 888 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Pauls Lutheran Balto Co Md

DATE OF BURIAL: Apl. 15, 1927

20-UNDERTAKER: John G. Bowman & Son

ADDRESS: 901 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21199

CERTIFICATE OF DEATH.

44 E 21199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2769 Pivoly Ave ST., 9-46 WARD)

2-FULL NAME Henry Miller

(a) RESIDENCE No. 2769 Pivoly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Miller

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. News.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Sweigert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Caroline Miller
(Address) 2769 Pivoly Ave

15 Filed APR 14 1927 HARRISON JONES, M. D. Registrar
By RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to April 12, 1927, that I last saw him alive on April 12, 1927, and that death occurred, on the date stated above, at 4:50 p. m.

The CAUSE OF DEATH* was as follows:

Metastatic Adeno-Carcinoma of left lung

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Primary Adeno-Carcinoma of Stomach (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 24, 1927

Was there an autopsy? No

What test confirmed diagnosis? Biopsy & Microscopical Examination of tissue

(Signed) Thos. R. Geraghty M. D.

1927 (Address) 2225 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakewood Cemetery	April 15 1927

20 UNDERTAKER Wm. H. Templeton ADDRESS 811 W. Fay Ave

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Braun

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21200 — 161-081 — E 21200

CERTIFICATE OF DEATH.

REGISTERED NO. C 13-52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Union Ave St.; 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Braun Jr

(Residence in Baltimore: No. Supra 1135 Union Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 13 (Day), 1927 (Year).

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2½ hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), 1135 Union Ave Balto Md.

PARENTS.

10-NAME OF FATHER, John Braun

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Lillian Kaeney

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. E. Beach M.D.

(Address) 2229 St Paul St

15-

Filed ..... 191..

Registrar.

Per .....

C. HAMPSON JONES, M.D.

APR 14 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 13 (Day), 1927 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 4/13 1927, to 4/13 1927, that I saw him alive on 4/13 1927, and that death occurred, on the date stated above, at 7m P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leonard E. Beach M. D.

4/13, 1927. (Address) 2229 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park	APR 14, 1927
20-UNDERTAKER	ADDRESS
J. W. Tenfelt & Son	501 N. Fayette

Spec.—12-9-25—A Co.—200 Bks.

E 21201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

E 21201

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj. Volosheu

(a) RESIDENCE NO. 2219 Eutaw Pl St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Bloshen

6 DATE OF BIRTH (month, day, and year) June 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
60	61	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Moses Volosheu

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Markam

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Nathan Volosheu

(Address) 2219 Eutaw Place

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-13-27

17

I HEREBY CERTIFY, That I attended deceased from 3-3-'27 to 4-13, 1927,

that I last saw h.im alive on 4-13, 1927,

and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma c metastases

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-11-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max H Kreuzfeld, M. D.

4/13 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem Date of Burial 4/14 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

APR 14 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21202 E 21202

CERTIFICATE OF DEATH.

REGISTERED NO. 1724 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Shields alley St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Greenwood

(a) RESIDENCE NO. 1118 Shields alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Beuson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About 68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Clark Construction Co.

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Greenwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Beuson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wm. T. Greenwood

(Address) 406 W. Hollins St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

APR 14 1927 Per ..... Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest January (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
arterio sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

(Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbury Cemetery Date of Burial April 15 1927

20 UNDERTAKER John H Green ADDRESS 538 Belair Ave

Spec.—12-9-25—A Co.—200 Bks.

VENABLE

HEALTH DEPARTMENT—CITY OF BALTIMORE

Jul 720 E 21203 — 32 E 21203

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 18-26 Ward)

2-FULL NAME Paul Venable

(a) RESIDENCE NO. 815 N. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Sing

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 6 1925

7 AGE — Years: 2 | Months: 1 2 | Days: 24 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Boise Venerable

11 BIRTHPLACE OF FATHER (city or town)

(State or country): N.C

12 MAIDEN NAME OF MOTHER: Violet Fountleroy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Records

(Address): Johns Hopkins Hospital

15 Filed APR 14 1927 G. Harris Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: April 12

17 I HEREBY CERTIFY, That I attended deceased from April 1 - 19 27, to April 12, 19 27,

that I last saw h.. alive on April 12, 19 27,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, tbc (?)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Is Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. O'Price, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — Date of Burial: April 14 1927

20 UNDERTAKER: John H Owens — ADDRESS: 538 2nd St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21204

CERTIFICATE OF DEATH

90 E 21204

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 2336 N. Calvert St. (Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Morrow

(a) RESIDENCE NO. 2336 N. Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Virginia Morrow

6 DATE OF BIRTH (month, day, and year) Oct. 20th 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. R. R.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas G. Morrow

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Bradford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Howard S. Swank

(Address) 2336 N. Calvert St

15 Filed APR 14 1927, 19 C. HARRY JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 13th. 1927

17 I HEREBY CERTIFY, That I attended deceased from January, 1927 to Apr 13, 1927

that I last saw him alive on Apr 13, 1927

and that death occurred, on the date stated above, at 10.25 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) Percy Remp M. D.

4/13 19 (Address) 2507 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa. Date of Burial Apr. 15th 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1005 N. Bond St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21205

CERTIFICATE OF DEATH.

129

E 21205

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 540 N. Bond ST., 1-9 WARD)

2-FULL NAME Susie Gross

(a) RESIDENCE NO. 540 N. Bond ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Gross

6 DATE OF BIRTH (month, day, and year): May 27, 1871

7 AGE: Years 36 | Months 10 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Michaels, Md.

PARENTS

10 NAME OF FATHER: Chas Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Michaels Maryland

12 MAIDEN NAME OF MOTHER: Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mary Wales 540 N. Bond

15 Filed 4 1927 19 HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/4/27, 19 , to 4/14/27, 19 ,

that I last saw her alive on 4/13/27, 19 ,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis and

Hepatitis

(Duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gunpowder

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. H. Blacker, M. D.

19 (Address) 1452 Fleet St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md.

DATE OF BURIAL: Apr. 14" 1927

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 Pike St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21206

CERTIFICATE OF DEATH

E 21206

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Price

(a) RESIDENCE NO. 126 S. Register St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oct 15/1920

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	5	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Pierce

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Mary Squires

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Wm. Pierce

(Address) 126 S. Register St

15 Filed APR 14 1927 C. HOWARD JONES, M. D. Registrar

Per R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd degree burns over face, arm, body etc. Accidental. Clothes caught from gas range. In her home.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

4/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 19 27

20 UNDERTAKER Kendall Dupple ADDRESS 37 Lan Av

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21207

CERTIFICATE OF DEATH.

E 21207
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 N. Bradford Ave Ward 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert C. Fader

(a) RESIDENCE NO. 607 N. Bradford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? Fifty mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Florence Fader

6 DATE OF BIRTH (month, day, and year): July 18-1878

7 AGE: Years 48 | Months 8 | Days 23 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Coal Driller
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md.

PARENTS

10 NAME OF FATHER: Charles Fader

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jinnie Bond

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Hartford Co

14 Informant: Florence Fader
(Address): 607 N. Bradford

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27 to April 12, 1927
that I last saw him alive on April 11, 1927
and that death occurred on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Pul Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. Lee Rountree M. D.
April 13 1927 (Address) 800 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: April 15 1927

20 UNDERTAKER: Wm C. Miller & Son — ADDRESS: 233 Jefferson St

very important. See instructions on back of certificates.

APR 14 1927 Pur

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21208

CERTIFICATE OF DEATH.

182 E 21208

REGISTERED NO._____

1-PLACE OF DEATH Found in Harbor foot Lancaster St

City of BALTIMORE: (No. East Falls missing St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Ritzel

(a) RESIDENCE NO. 302 Block N Exeter St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: ~~1 0~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of &&&&&&&&&&&&&&&

6 DATE OF BIRTH (month, day, and year) Aug. 23rd. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
61	62	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Broom Business
(b) General nature of industry, business, or establishment in which employed (or employer) Helper
(c) Name of employer John C. Ritzel

9 BIRTHPLACE (city or town) Philadelphia Pa.
(State or country)

PARENTS

10 NAME OF FATHER Conrad Ritzel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Schnaufer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Jno. C. Ritzel
(Address) 1752 Orleans St.

15 Filed APR 6 1927, 19____ Per _____ Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) ____ yrs. Sudden ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) James H. Pentz M. D.
(Coroner)

4/14, 192 7 (Address) 700 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial 4/14/ 1927

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21209

CERTIFICATE OF DEATH.

E 21209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2107 Elsinor ave ST. 15-61 WARD)

2-FULL NAME Laura E. Wolf.

(a) RESIDENCE NO. 2107 Elsinor ave ST., WARD Penna.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16. 1851

7 AGE — Years: 75 — Months: 6 — Days: 28 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.J.

PARENTS

10 NAME OF FATHER Gabriel Dilkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Mary A. Boud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila.

14 Informant Mary Wolf. Wilkins (Address) Elsinor ave. Penna.

15 Filed C. HAMPSON JONES, M. D. Registrar

4 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 9 1924 to Apr 14 1927.

that I last saw h[illegible] alive on apr 14 1927.

and that death occurred, on the date stated above, at 1. 20 a m.

The CAUSE OF DEATH* was as follows:

Labor pneumonia

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary) Labor pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Hall S Riblett, M. D.

4/14, 1927 (Address) 2220 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila. Penna. DATE OF BURIAL: April 14 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21210 — CERTIFICATE OF DEATH — E 21210

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO. 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Mrs Hattie Purdy

(a) RESIDENCE NO. Laurel, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ed. Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Goodwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Hattie Purdy

15 Filed APR 14 1927 — HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to April 13, 1927, that I last saw h[illegible] alive on April 13, 1927, and that death occurred, on the date stated above, at 4[illegible] A. m.

The CAUSE OF DEATH* was as follows:

Chronic Peritonitis (Primary)

(duration) ..... yrs. ..... mos 1 6 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 4-3-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. A. Longwell, M. D.

, 19 (Address) 1415 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery Laurel Md — DATE OF BURIAL April 16 1927

20 UNDERTAKER Edward A Tschiffely — ADDRESS Laurel Md

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21211

CERTIFICATE OF DEATH.

E 21211

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. 6 tte 11 E Dillon St.) (3 E 26 3 Ward)

2-FULL NAME John Phillip Riegel

(a) RESIDENCE NO. Eastern Ave E Mar[illegible] St. Essex Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary C. Stickland

6 DATE OF BIRTH (month, day, and year) Jan 29 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	7	16	15

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician 29
(b) General nature of industry, business, or establishment in which employed (or employer) Elec. Light Dept.
(c) Name of employer Gas & Elec. Co

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER William Riegel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliz Kelly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary C. Riegel
(Address) Eastern Ave. Essex

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

1 Acc. Electrocuted Light

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (secondary)

(duration) ... yrs. ... mos. ... ds.

Apr 17 (Signed) H C Yates M. D.

19 (Address) 143 W 31st

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial 4/18 1927

20 UNDERTAKER John G. Connelly ADDRESS Essex

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 189✓

E 21212

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 6-9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Huff

(a) RESIDENCE NO. Street, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: 38 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 08

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): "

14 Informant: Hospital Record.

(Address)

15 Filed ..... 19 ..... Registrar

PR 14 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 14

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927 to April 14, 1927

that I last saw h.im alive on April 14, 1927,

and that death occurred, on the date stated above, at 12:10 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Fracture 5th Lumbar vertebra

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Apr. 9, 1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. Clark Grove, M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Powers & Cra. Harford Co. Md. Date of Burial 4/15 1927

20 UNDERTAKER: Herbert S. Bailey ADDRESS: Darlington Md.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21213 E 21213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 St Paul St. (Ward) 17-19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Moses

(a) RESIDENCE NO. 1700 St Paul ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1st 1850

7 AGE: Years 77 (76) | Months 6 | Days 6 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Allentown Pa

PARENTS

10 NAME OF FATHER B.J. Hagenbuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Allentown Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Allentown Pa

14 Informant Mrs. H. C. Steckel

(Address) 1700 St Paul St

15 Filed ....., 19..... C. HAMPTON JONES, M. D. Registrar

147927 Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1926, to April 12, 1927, that I last saw her alive on April 12, 1927 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

~~Sarcoma~~

Sarcoma of Ovary

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

, 19 (Address) 3 W. Biddle St, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Allentown Pa — DATE OF BURIAL: April 15 1927

20 UNDERTAKER: Henry J. Jenkins & Son Co — ADDRESS: Eutaw & Lafayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 21214

E 21214 DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1626 Chalk alley St.; 16-72 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Caulk

(a) RESIDENCE NO. 1626 Chalk alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elias Caulk

6 DATE OF BIRTH (month, day, and year) about 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer 0

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Saunders

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hetty Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Elias Caulk
(Address) 1626 Chalk alley

15 Filed ..... 19.....

C. HAMILTON JONES, M. D.
Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage.

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) .....yrs. .....mos. .....ds.

(Signed) J. F. Hennessy M. D.
(Coroner)

April 12, 1927 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery Date of Burial 4/14/1927

20 UNDERTAKER Hatie R. Williams ADDRESS 922 N. Schroeder St

very important. See instructions on back of certificate.

APR 14 1927

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21215

CERTIFICATE OF DEATH.

118-002

E 21215

1-PLACE OF DEATH 1213 S. Light St

City of BALTIMORE: (No. South Balt. Hospital St., 73-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Pickering

(a) RESIDENCE NO. 36 Poultney St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Pickering

6 DATE OF BIRTH (month, day, and year): Oct 29, 1877

7 AGE: Years 49 | Months 5 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Adam Hand

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Mulcahey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Margaret Wright

(Address) 36 Poultney St

15 Filed APR 14 1927 C. HAMILTON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to April 11, 1927,

that I last saw her alive on April 11, 1927,

and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 4/10/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. Miller, M. D.

, 19 (Address) South Balt Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: April 14 19 27

20 UNDERTAKER: Margaret S. Flynn — ADDRESS: 1422 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21216

CERTIFICATE OF DEATH.

132

E 21216

1-PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 17-12 WARD)

2-FULL NAME Gertrude Lightner

(a) RESIDENCE NO. 2318 1823 Ashland. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of James H. Lightner

6 DATE OF BIRTH (month, day, and year) Dec. 18-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
43	44	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas A. Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina,

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada.

14 Informant James H. Lightner

(Address) 2318 Ashland Ave

Filed APR 14 1927, 19 C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 19 27

17

I HEREBY CERTIFY, That I attended deceased from March 25, 19 27. to April 12, 19 27.

that I last saw her alive on April 12, 19 27,

and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH* was as follows:

Stones in Common Bile duct

Liver abscess. (multiple).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Thrombosis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical, autopsy.

(Signed) Clement R. Worrall, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL April 15th 19 27

20 UNDERTAKER Lilly and Zilm 403 ADDRESS S Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

E 21217

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21217

CERTIFICATE OF DEATH.

REGISTERED NO. 10-14 '29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 926 ST. Stirling (WARD) 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stokes

(a) RESIDENCE NO. 926 ST. Stirling WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 9 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Nelson Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mamie Stokes 926 Stirling St.

15 Filed APR 14 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1927, to April 10, 1927, that I last saw him alive on April 10, 1927 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of urine

(Signed) Robert L. Green, M. D.

4-13, 1927 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL Apr. 14 1927

20 UNDERTAKER Mrs. Robert A. Elliott ADDRESS 725 Gaaland

TION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21218

CERTIFICATE OF DEATH.

100-001

E 21218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1214 Division ST. 17-24 (WARD)

2-FULL NAME Hamet Louis Bailey

(a) RESIDENCE NO. 1214 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1214 Division St Baltimore Md

PARENTS

10 NAME OF FATHER Robt. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robt Bailey (Address) 1214 Division St

15 Filed APR 14 1927 Per [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10 1927 to April 14th 1927 that I last saw h[illegible] alive on April 13th 1927 and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

(Address) 914 Mod. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wakefield Va

DATE OF BURIAL April 14/8.27

UNDERTAKER Harold Eaton

ADDRESS 916 Eye St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21219

CERTIFICATE OF DEATH.

188-001

E 21219

1-PLACE OF DEATH

City of BALTIMORE: (No. Penna. R.R. Tunnel 16-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Taylor

(a) RESIDENCE NO. 809 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie Taylor

6 DATE OF BIRTH (month, day, and year) about 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer Penna

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant George Taylor

(Address) 809 N. Carey St.

15 Filed April 19 27 J. M. C. JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry) had that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

Fracture of right femur & tibia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) R.R. accident

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

April 14, 19 27 (Address) 280 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. Date of Burial April 14 1927

20 UNDERTAKER Daniel Easton ADDRESS Eaue.

very important. See instructions on back of certificate.

APR 19 1927 C. HAYWARD JONES, M. D.

Hayward

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21220

100-001

CERTIFICATE OF DEATH.

REGISTERED E 21220

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St 16-22 Ward)

2-FULL NAME Zerita Duppins Bond

(a) RESIDENCE NO. 1018 Parrish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 24/25

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Bond (Foster)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Duppins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Edna Duppins

(Address) 1018 Parrish St

15 Filed ....., 19.. C. HAMILTON ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Bauer M. D.
(Coroner)

4/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial April 14/27

20 UNDERTAKER Daniel Easton ADDRESS 916 Ca ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21221

CERTIFICATE OF DEATH.

3/ E 21221

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 385. Potomac ST. 1-7 WARD)

2-FULL NAME Anton J. Urban Jr.

(a) RESIDENCE NO. 385 Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mary Urban

6 DATE OF BIRTH (month, day, and year): Feb. 9, 1889

7 AGE — Years: 38 — Months: 2 — Days: 4 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Not employed

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Anton J. Urban Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cechs-Slovakia

12 MAIDEN NAME OF MOTHER: Josephine Musil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cechs-Slovakia

14 Informant: Edward J. Urban

(Address) 800 N. Curley St

15 Filed APR 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1926, to April 13, 1927.

that I last saw h~~im~~/~~er~~ alive on April 13, 1927

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Jooka M. D.

, 19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem. — DATE OF BURIAL: April 16 1927

20 UNDERTAKER: August Pasek — ADDRESS: 840 Ashland ave.

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 ✓

REGISTERED NO. E 21222

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 S. Louden Ave St. 20-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Roberts.

(a) RESIDENCE NO. 125 S. Louden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Leona Roberts.

6 DATE OF BIRTH (month, day, and year) July 17 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58.	8	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman. 16

(b) General nature of industry, business, or establishment in which employed (or employer) — 08

(c) Name of employer —

9 BIRTHPLACE (city or town) Somerset Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Roberts.

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.

(State or country) Md.

14 Informant Thelma Andrews

(Address) 125 S. Louden Ave

15 Filed APR 14 1927 HAMILTON JONES, M. D. Registrar

For R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-23- 1927, to 4-13- 1927,

that I last saw h[illegible] alive on 4-12- 1927,

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum & Pylorus

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY none
(Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & X-ray.

(Signed) Chester Roland, M. D.

4-13-1927 (Address) 2532 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Date of Burial April 15 1927

20 UNDERTAKER Harry H. Wetzel ADDRESS 1131 W. Lombard St

very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21223

CERTIFICATE OF DEATH.

E 21223

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Marie Oetken

(a) RESIDENCE NO. 1226 Sargeant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Oetken

6 DATE OF BIRTH (month, day, and year) Aug 6. 1873

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or min.
	53	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Schlenker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Oetken

(Address) 1226 Sargeant St

15 Filed 4 14 1927 19 HAMILTON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-1927.

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1927, to 4-13, 1927, that I last saw h m alive on 4-13, 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Multiple abscesses from Sepsis, primary cause undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-7-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests

(Signed) Otheron Hunter, M. D.

4/13, 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL April 16 1927

20 UNDERTAKER Harry H. Wetzler

ADDRESS 1531 W Lombard St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21224

CERTIFICATE OF DEATH.

E 21224

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Aquilla & Ashland Ave ST.) 14-28 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M Philip Neri -

(a) RESIDENCE NO. 103 S Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Notre Dame Convent

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Neri

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Walder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Sr. M. Kostka
(Address) St Joseph Hosp

15 Filed 4-14-1927, 19 C. HARRISON JONES, M. D. Registrar
Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927, to April 13, 1927, that I last saw her alive on April 9, 1927, and that death occurred, on the date stated above, at 9 pm m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - Influenzal.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Clement R. Monroe, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	April 16 1927
20 UNDERTAKER Frank A. Finke	ADDRESS 916 N. Gay St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21225

CERTIFICATE OF DEATH 101-001

E 21225

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2029 E. Preston St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Crowder

(a) RESIDENCE NO. 2029 E. Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine A. Crowder

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	69	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Daniel Conn 0.50

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Catherine A. Crowder

(Address) 2029 E. Preston St

15 Filed APR 4 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927, to April 12, 1927, that I last saw him alive on April 12, 1927, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Toxaemia and Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Albert C. Bowman M. D.

4/13, 1927 (Address) 2029 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial Apr. 15 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21226

E 21226

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2035 Hollins ST. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank H Stauffer

(a) RESIDENCE NO 2035 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Stauffer

6 DATE OF BIRTH (month, day, and year) 3-10-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W Stauffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Henrietta C Counselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Herbert Stauffer

(Address) 2035 Hollins St

15 APR 4 1927 C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1925 to April 12, 1927, that I last saw him alive on April 12, 1927, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

4/12, 1927 (Signed) L D Britton M. D.

(Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Apr. 16 1927

20 UNDERTAKER George L. Schmidt ADDRESS 1101 Eutaw St.

TION is very important. See instructions on back of certificate

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21227

CERTIFICATE OF DEATH.

113 E 21227

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1542 Argyle Ave St. 14-20 Ward)

2-FULL NAME Evelyne L. Ridgely

(a) RESIDENCE NO. 1542 Argyle Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 4, 1927.

7 AGE: Years ____ Months 3 Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nursing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) April 1927

(State or country) Md.

PARENTS

10 NAME OF FATHER George Ridgely

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Selina Ridgely

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant George Ridgely

(Address) 1542 Argyle Ave

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary) no history of contagious diseases

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Kennedy, M. D.

(Coroner)

April 14, 1927 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt. Lookout | Date of Burial April 14 1927

20 UNDERTAKER Sam H. Chase Son | ADDRESS 140 N. Mar

E 21228

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21228

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1108 McCulloh St.) (WARD) 24

2-FULL NAME Pete Namnach

(Residence in Baltimore: No. Detained St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word)
M	C	

6-DATE OF BIRTH ..... (Month) 4 (Day) 10, 1927 (Year)

7-AGE ..... yrs. ..... mos. 1 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md.

PARENTS

10-NAME OF FATHER Pete Namnach

11-BIRTHPLACE OF FATHER (State or country) U. S.

12-MAIDEN NAME OF MOTHER Rose Smith

13-BIRTHPLACE OF MOTHER (State or country) U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Altbaumhaus

(Address) 1202 Hollins

15 Filed 4 1927, 191 ..... C. HAMPSON JONES, M. D. Registrar

1253

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH ..... (Month) 4 (Day) 13, 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-12, 192., to 4-13, 1927, that I saw her alive on 4-13, 1927, and that death occurred, on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Altbaumhaus M. D.

4-13, 192., (Address) 1202 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... ,191.

20-UNDERTAKER | ADDRESS

Is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21229

CERTIFICATE OF DEATH.

X-21 E 21229

REGISTERED NO. 4-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., WARD)

2-FULL NAME Albert Rutledge

(a) RESIDENCE NO. Laurel, Prince Geo. Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Rutledge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cynthia Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record (Address)

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Pay

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to April 14, 1927, that I last saw h[illegible] alive on April 14, 1927, and that death occurred, on the date stated above, at 2 15 a. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 8 da.

CONTRIBUTORY (Secondary) Bilateral Bronchopneumonia

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

4/14 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lt Mayo Cem Laurel Md | DATE OF BURIAL 4/16/27

20 UNDERTAKER E & B Harle | ADDRESS 115 E [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21230

21230

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1622 N Montford St., Ave 256 WARD)

2-FULL NAME Lorenzo D Gray

(a) RESIDENCE NO 1622 N Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Gray

6 DATE OF BIRTH (month, day, and year): May 30 1860

7 AGE: Years 66 Months 10 Days 14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk American 009

(b) General nature of industry, business, or establishment in which employed (or employer): Railway Express Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mayoty Md

PARENTS

10 NAME OF FATHER: Stephen Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mayotty Md

12 MAIDEN NAME OF MOTHER: Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mayotty Md

14 Informant: Mrs Josephine Gray

(Address) 1622 N Montford ave

15 4 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 13. 1927. to Apr. 13. 1927.

that I last saw him alive on Apr. 10. 1927.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

4/13. 1927 (Address) 1823 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: April 16 1927

20 UNDERTAKER: John T Denny — ADDRESS: 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21231

CERTIFICATE OF DEATH.

15-21 188-001

E 21231

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh Mann

(a) RESIDENCE NO. 1601 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Mann

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Coverer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Emmert Mann

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Nettie Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Bertha Mann

(Address) 1601 N. Gilmor St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of pelvis over

(duration) abt 2 hrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene between bone & urs.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

April 12 1927 (Address) 702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dinwiddie Va Date of Burial April 15 27

20 UNDERTAKER John F Denny ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21232

CERTIFICATE OF DEATH.

40 E 21232

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Wilson

(a) RESIDENCE NO. 1507 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col-

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Cora Wilson

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 630

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: James A Wilson

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Isabella Carey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Santoris Jackson

(Address) 1507 W Mulberry St

15 Filed 4 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 4-12-27

17 I HEREBY CERTIFY, That I attended deceased from 4-6-, 1927, to 4-12, 1927, that I last saw him alive on 4-12, 1927, and that death occurred, on the date stated above, at 4-27 m.

The CAUSE OF DEATH was as follows:

Streptococcic Meningitis

Diabetes Mellitus with Glycosuria & Ketosis

Fatigue Atrophy of Pancreas Autopsy

Alcoholism ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-6-27

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) J. Blackwell, M.D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: 4-17 1927

20 UNDERTAKER: Jas. In. Skinner

ADDRESS: 1625 E. Broadway

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21233

HEALTH DEPARTMENT—CITY OF BALTIMORE

Vol 101 E 21233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1004 W Barn (ST.) (WARD) 21-29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida B. Brooks

(a) RESIDENCE NO. 1004 W. Barn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced (Husband) of (or) WIFE of: Robert Brooks

6 DATE OF BIRTH (month, day, and year): Aug 3-1863

7 AGE: 63 Years 8 Months 16 Days; If LESS than 1 day, hrs or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Nelson Blunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Pusper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Robert Brooks

(Address) 1004 W Barn St

15 Apr 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927, to April 13, 1927, that I last saw h[illegible] alive on Apr 12, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) J. M. Delaney, M. D.

Apr 13, 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4-15-1927

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hilton

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21234

CERTIFICATE OF DEATH.

179 E 21234

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 75-77 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Lubickas

(a) RESIDENCE NO. 1800 Curtis St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oil Cars
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Kaspar Lubicas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Barbara Siemuk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Jos. Lubicas
(Address) 1174 N. Bond

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 3rd degree on body
Complications
Clothes caught fire while preparing
CONTRIBUTORY (Secondary) fire and nearly from
Duration yrs. mos. ds.
Apr. 14 Signed Journal burn of face
(Coroner)
, 1927 Address 1679 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R.R. Date of Burial April 15 1927

20 UNDERTAKER John Grebliauskas ADDRESS 423 S. Paca St.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21235

CERTIFICATE OF DEATH.

100-1001 ✓

E 21235

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO._____

City of BALTIMORE: (No. [redacted] St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Haid

(a) RESIDENCE NO. 208 E. 22nd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	? Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May 13. 78

6 DATE OF BIRTH (month, day, and year) May 13, 1843

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83 (84)	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER ? John Haid

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) ? Germany

12 MAIDEN NAME OF MOTHER ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) ? Germany

14 Informant _____

(Address) Records

15 Filed APR 4 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to April 13, 1927, that I last saw h[redacted] alive on April 13, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) C. H. Hoppenstedt, M. D.

April 13 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Apr 15 1927

20 UNDERTAKER William Cook ADDRESS 527 E. Lex[illegible]

very important. See instructions on BACK of CERTIFICATE.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21236

CERTIFICATE OF DEATH.

128 E 21236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 N. Fulton - St. 16-21 WARD)

2-FULL NAME William G. Peregoy

(a) RESIDENCE NO. 1305 N. Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola E. Peregoy

6 DATE OF BIRTH (month, day, and year) Oct 15/84

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe fitter

(b) General nature of industry, business, or establishment in which employed (or employer) general heating & construction work

(c) Name of employer Hughes Eggiman & Bodkin Co.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Isabella Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Viola E. Peregoy

(Address) 1305 N. Fulton Ave

15 Filed APR 14 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1927, to Apr 14, 1927, that I last saw him alive on Apr 14, 1927, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

uremic convulsions & coma -

CONTRIBUTORY (Secondary) nephritis (acute) (duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Catherine Ford Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinal tests

(Signed) H. E. Hurst M. D.

, 19 (Address) 1001 N. Fawcett

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Apr 18 1927

20 UNDERTAKER Tatham Cook — ADDRESS 607 E. Monument

Cor.—13-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21237

CERTIFICATE OF DEATH.

198 E 21237

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. D-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Elkovsky

(a) RESIDENCE NO. 1602 Flint St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nurse Elkovsky

6 DATE OF BIRTH (month, day, and year) March 9, 1877

7 AGE	Years	Months	Days	If less than 1 day ....hrs. or ....min.
	50	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinsmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Shutterberger

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Mrs Louis Levy

(Address) Essex Md

Filed Apr 15 1927 19 CHAMPION JONES M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Stab Wound of Abdomen

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

Apr 14 27 Signed C. E. Radcliffe M. D.

(Coroner)

(Address) 143 W. Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Apr 16 1927

20 UNDERTAKER Pulsom Corp ADDRESS 502 E Northern

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21238 ~~E 21238~~ 129 E 21238

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No.) St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Owen

(a) RESIDENCE NO. 1624 N. Charles St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
~~Male~~	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winifred Owen

6 DATE OF BIRTH (month, day and year) Oct 16, 1861

7 AGE Years	Months	Days	IF LESS than 1 day....hrs. or....min.
65	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Wales

(State or country)

PARENTS

10 NAME OF FATHER Evan Owen

11 BIRTHPLACE OF FATHER (city or town) Wales

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Owen

13 BIRTHPLACE OF MOTHER (city or town) Wales

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

very important. See instructions on BACK OF CERTIFICATE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 6 1927, to April 14, 1927, that I last saw h. alive on April 14, 1927, and that death occurred, on the date stated above, at 1 2 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Uremia Hypertension

Chr. nephritis (duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H C Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Granite Md Date of Burial Apr 16 1927

20 UNDERTAKER Wilson Cook ADDRESS 502 E Mark St.

Spec.—1-12-23—M&T—500 Bks.

E 21239

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21239

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. 22-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Hughes ST. [illegible] WARD)

2-FULL NAME Carrie Sharine

(a) RESIDENCE NO. 115 Hughes ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sharine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Nellie Disco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East Ville Va

14 Informant John Marine (Address) 115 Hughes St

15 Filed 19 Registrar

C. HAMPTON JONES, M. D.

APR 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/1927

17 I HEREBY CERTIFY, That I attended deceased from 4/6, 1927, to 4/12, 1927,

that I last saw her alive on 4/12, 1927,

and that death occurred, on the date stated above, at 8.15A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Hypostasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Atypical & History

(Signed) W. W. Bishop, M. D.

, 19 (Address) 709 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL April 15 1927

20 UNDERTAKER C. W. Brown & Son

ADDRESS 108 Mulberry

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21240

CERTIFICATE OF DEATH.

E 21240

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1119 Ething St. 17-24 (Ward)

2-FULL NAME Ellen Gleaves

(a) RESIDENCE NO. 1119 Ething St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Gleaves

6 DATE OF BIRTH (month, day, and year): Nov. 1869

7 AGE: Years 58 Months 1 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Service

(b) General nature of industry, business, or establishment in which employed (or employer): 1120

(c) Name of employer

9 BIRTHPLACE (city or town): Easton

(State or country): Md.

PARENTS

10 NAME OF FATHER: Chas. Dent

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Ann Dorne

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mamie Jefferson

(Address): 1119 Ething St

15 Filed 4/15 1927 19 C. RAMPLEY JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/12 1927

I HEREBY CERTIFY, That I attended deceased from Jan. 27 1927 to April 12 1927

that I last saw h... alive on April 11, 1927

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ...yrs. 4 mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Compernass M. D.

(Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery

Date of Burial: 4/15/1927

20 UNDERTAKER: Mrs. George H. Holland

ADDRESS: 1631 Druid Hill Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21241

1-PLACE OF DEATH

City of BALTIMORE: (No. 948 W Lombard St., 18-29 Ward)

2-FULL NAME Michael Gannon

(a) RESIDENCE NO. 948 W Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

101-001

E 21241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced. HUSBAND of (or WIFE of): Celia McHugh Gannon

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years: 50. Months: Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor for City

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Ireland.

PARENTS

10 NAME OF FATHER: Michael Gannon

11 BIRTHPLACE OF FATHER (city or town): (State or country) Ireland.

12 MAIDEN NAME OF MOTHER: Ellen Nester

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Ireland.

14 Informant: Mrs. Celia Gannon

(Address) 948 W Lombard St.

15 Filed ..... 19 ..... E. HARRISON JONES, M. D. Registrar

APR 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10. 1927, to Apr. 12. 1927, that I last saw him alive on Apr. 12. 1927, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam, Etc.

(Signed) Thos. Watkins, M. D.

4/14/27 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery Date of Burial 4/16/1927

20 UNDERTAKER: Geo F J Cowan & Son ADDRESS Geo F J Cowan 901 Walker St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21242

CERTIFICATE OF DEATH.

88 E 21242

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 W Fratt St. St. 19-28 Ward)

2-FULL NAME Bridget M. Sweeney

(a) RESIDENCE NO. 1416 W Fratt St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Denis M. Sweeney

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) _____

(State or country) Ireland

PARENTS

10 NAME OF FATHER Jeremiah O'Rourke

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 Informant Mrs Margaret Bailey

(Address) 1416 W Fratt St

Filed MAR 7, 19 C. HAMILTON JONES, M. D.

MAR 15 1927 Per R.H. Registrar

very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4 1927, to March 13, 1927, that I last saw h[illegible] alive on March 12, 1927, and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ____ yrs. ____ mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) M. A. O'Neill, M. D.

MAR 14, 1927 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem Date of Burial Mar 16 1927

20 UNDERTAKER John F. Cannon & Son ADDRESS 901 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21243

CERTIFICATE OF DEATH.

84 E 21243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2519 Liberty Heights ave ST. (Ward)

2-FULL NAME Samuel Kaplan

(a) RESIDENCE NO. 2519 Liberty Heights ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Kaplan

6 DATE OF BIRTH (month, day, and year) Dec 29 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchants

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Aaron Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Liba —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rose Kaplan

(Address) 2519 Liberty Heights ave

15 Filed APR 15 1927 C. HAMPSON JONES, M. D. Registrar

For R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to April 14th, 1927, that I last saw he was alive on April 14th, 1927 and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Eugene F Leopold, M. D.

, 19 (Address) 200 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd — DATE OF BURIAL 4/15 1927

20 UNDERTAKER Jack Levis — ADDRESS 1439 Essex

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21244

CERTIFICATE OF DEATH.

12 E 21244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 dr High Street ST. 5 8 WARD)

2-FULL NAME Hyman Cohen

(a) RESIDENCE No. 207 dr High St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leah Cohen

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rag Peddler

(b) General nature of industry, business, or establishment in which employed (or employer): 645

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris L. Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Linda Chuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Leah Cohen 207 dr High St

15 Filed 19.. Registrar

R 7 5 1927 C. HAMPSON JONES, M. D.

Reg. RK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927, to April 14, 1927, that I last saw him alive on April 14, 1927, and that death occurred, on the date stated above, at 3.0 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 2-1 ds.

CONTRIBUTORY (Secondary): nephritis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Exam

(Signed) Solomon Sherman, M.D., M. D.

, 19 (Address) 2036 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Mahesen Cem

DATE OF BURIAL: 4/15 1927

20 UNDERTAKER: Jack Lewis 1439 Edsall Ave

ADDRESS

FOR IS very important. See instructions on back.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21245

CERTIFICATE OF DEATH.

E 21245

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 731 Dolphin St., (Int. 17-24) WARD 90

2-FULL NAME Lucretia Johnson

(a) RESIDENCE NO. 731 Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colord

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1847

7 AGE: Years 80 | Months — | Days — | If LESS than 1 day, ... hrs or ... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore city

PARENTS

10 NAME OF FATHER: dont no

11 BIRTHPLACE OF FATHER (city or town) (State or country): dont no

12 MAIDEN NAME OF MOTHER: dont no

13 BIRTHPLACE OF MOTHER (city or town) (State or country): dont no

14 Informant: Rend Simms
(Address) 731 Dolphin St

15 Filed APR 15 1927 C. HAMPSON JONES, M. D.
Per R.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to April 12, 1927, that I last saw h[illegible] alive on April 12, 1927, and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

1 Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J.R. Cobley, M. D.

, 19 (Address) 709 Leadenhall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 4-15 1927

20 UNDERTAKER: John H. Joachim — ADDRESS 1027 Hanover

Spec.—1-12-23—M&T—500 Blks.

E 21246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21246

REGISTERED NO. 1925-90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Visitation Convent St. 1 Precinct (WARD)

2-FULL NAME Sr. Mary Angela Jenkins

(a) RESIDENCE NO. Visitation Convent ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 1 mo. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Religious

6 DATE OF BIRTH (month, day, and year) Mar 8th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alfred Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Hinkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Convent Record

(Address)

15 Filed APR 15 1925

16 C. HAMPSON JONES, M. D. Registrar

Per R. H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1925

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1925, to April 14, 1925,

that I last saw h[illegible] alive on April 13, 1925

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Influenza - following fracture of Right hip

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) arg. Dis. heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

April 17, 1925 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 18 1925

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS McCulloh & Eutaw Sts.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21247

CERTIFICATE OF DEATH.

48 E 21247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 N Lexington St. 4th WARD)

2-FULL NAME Lissette Nobbe

(a) RESIDENCE NO. 746 N Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 5 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) March 30 1840

7 AGE	Years	Months	Days 13	If LESS than 1 day, hrs. or min.
	87	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Wm. Brinkley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augsburg Home Recvd (Address) 746 N Lexington St

15 Filed APR 5 1927 By C. HAMPTON JONES, M. D. Registrar For R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1925 to April 13 1927.

that I last saw her alive on April 13 1927.

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) 3 yrs. - mos - ds.

CONTRIBUTORY (Secondary) Myocarditis -

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Edw. H. Kemmler M. D.

4-14-1927 (Address) 300 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls. Druid Hill Park

DATE OF BURIAL 4 - 15 1927

20 UNDERTAKER Mrs Chas A G Rohde

ADDRESS 22 N Arlington Ave

Spec.–7-17-26—A Co.—200 Bks.

E 21248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E. 21248

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3915 Lloyd ave St. 5-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara E. Moseley

(a) RESIDENCE NO. 3915 Lloyd Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: Eugene E. Moseley

6 DATE OF BIRTH (month, day, and year): Nov. 26th 1861

7 AGE: Years 65 Months 4 Days 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John Kaspar

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Bohemia.

12 MAIDEN NAME OF MOTHER: Mary Westcott

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Bohemia

14 Informant: C. F. Young

(Address): 3915 Lloyd ave

C. HAMPSON JONES, M. D.

15 Filed 19

Registrar

R 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 22 19 27 to Apr. 12 19 27.

that I last saw h[illegible] alive on Apr. 12 19 27.

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Lab.

(Signed) James E. Gould M. D.

4/14 1927 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Italy Redeemer Cemetery

Date of Burial: Apr 16 19 27

20 UNDERTAKER: Ruth Turner Funeral Home

ADDRESS: 1422 N. Gay

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21249

CERTIFICATE OF DEATH.

22-002

E 21249

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1837 E. Chase St., 11-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Lewis

(a) RESIDENCE NO. 1837 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Lewis ~~Aug 3 1863~~

6 DATE OF BIRTH (month, day, and year): Aug 3/63

7 AGE — Years: 63 — Months: 8 — Days: 10 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Truckman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O RR

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): "

14 Informant: Albert T. Lewis

(Address): Essex Md

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Collins M. D.

(Coroner)

4/IX 1927 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood cemetery — Date of Burial: apr. 15 1927

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 E. [illegible]

APR 15 1927

very Important. See instructions on back of Certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21250

CERTIFICATE OF DEATH.

E 21250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST. 12-51 WARD)

2-FULL NAME Frank Mogue

(a) RESIDENCE NO. 40 Union Ave., Brooklyn ST. N.Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.... min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of Industry, business, or establishment in which employed (or employer) U. S. Navy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Porto Rico

PARENTS

10 NAME OF FATHER Manuel Canidens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER — Mogue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Porto Rico

14 Informant Hospital Records

(Address)

15 Filed APR 15 1927, 19 C. HAMPSON JONES, M.D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to April 14, 1927, that I last saw him alive on April 14, 1927, and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (~~Acute~~ epidemic type)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings, laboratory tests, autopsy findings

(Signed) C. W. Dengo, M. D.

4/15, 1927 (Address) Asst Surgeon U.S.P.H.S. U. S. Marine Hospital, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 4/15/1927

UNDERTAKER E. LeRoy Stiffler

ADDRESS 1256 North Ave

Over

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21251 — REGISTERED NO. 31 E 21251

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1333 Valley ST. 9-18 WARD)

2-FULL NAME Melvin D. Disselberger

(a) RESIDENCE NO. 1333 Valley ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life 8 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gilberta Disselberger

6 DATE OF BIRTH (month, day, and year): Feb 25 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R. R. Trackman

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired RR

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Disselberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Minnie Wiechert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Minnie Disselberger 1333 Valley St

15 Filed APR 15 1927 HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/1 1926, to 4/13 1927, that I last saw h~~im~~ alive on 4/13 1927, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. 13 ds.

CONTRIBUTORY (Secondary): Arthritis & Heart failure

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay B Dunbar, M. D.

, 19 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: April 16 1927

20 UNDERTAKER: Bertram Bye — ADDRESS: 1723 N Fulton Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21252

1-PLACE OF DEATH
E 21252

CITY OF BALTIMORE: (No. 214 Oakdale Road, Roland Park ST. 27-53 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Pearce Johns

(a) RESIDENCE NO. 214 Oakdale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes E. Mathaney

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Builder & Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard H. Johns

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret A. Pearce

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant T. Morris Johns
(Address) 214 Oakdale Road

15 Filed APR 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6 1927 to April 13 1927.
that I last saw him alive on April 13 1927.
and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis - 10 yrs +
Coronary embolism
(duration) yrs. mos. 38 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) A. F. Robinson, M. D.

4-14 1927 (Address) 836 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 4/16 1927

20 UNDERTAKER Henry W. Spears & Son

ADDRESS 805 N. Calvert

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21253

CERTIFICATE OF DEATH.

31

E 21253

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Mosher St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Horsey

(a) RESIDENCE NO. 1705 Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25, 1895

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
32	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salisbury

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Dorrington

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mary L. Butler

(Address) 1705 Mosher St.

15 Filed APR 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Did not see patient alive, 19...., that I last saw h... ative on ....., 19....., and that death occurred, on the date stated above, at 7.42 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T B

(duration) ...yrs. 6 mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! no

What test confirmed diagnosis!

(Signed) J. W. Hawkins, M. D.

4/15, 1927 (Address) H. Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury, Md. Date of Burial April 16, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 E. Schroeder St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21254

CERTIFICATE OF DEATH.

21-29

17 E 21254

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 W. Hamburg ST., WARD)

2-FULL NAME William W. Byron

(a) RESIDENCE NO. 1153 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Flora E. Byron

6 DATE OF BIRTH (month, day, and year) May 24 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Carnegie Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Flora E. Byron

(Address) 1153 W. Hamburg St

Filed [illegible] 19 [illegible] Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10 1927 to April 14 1927

that I last saw h. alive on April 14 1927

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) John G. Chrystie M.D.

19 (Address) 1126 Wilson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawn

DATE OF BURIAL Apr. 16 1927

20 UNDERTAKER Frs. Thos. J. W. Pimpel & Son

ADDRESS 201 N. Fayette

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21255

CERTIFICATE OF DEATH

REGISTERED NO. E 21255

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 Callendar St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mc Kay

(a) RESIDENCE NO. 118 Callendar St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May, 4th. 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas Supply Co.

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Mr. McKay

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Unknown

14 Informant Catherine McKay

(Address) 118 Callendar St.

15 Filed APR 5 1927 19 C. HARRISON JONES, M. D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 13th. 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/12 19 27 to 4/13 19 27

that I last saw him alive on 4/13 19 27

and that death occurred, on the date stated above, at 8.08 P. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

History 1½

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not, at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) Bernard J. Fury M. D.

4/14 19 27 (Address) 910 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

Date of Burial Apr. 16" 19 27

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W Balto St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21256

CERTIFICATE OF DEATH.

74-001

E 21256

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hunt

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Hunt

6 DATE OF BIRTH (month, day, and year) Feb 15th 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	1	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Phillip Hunt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Kate McGee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed APR 15 1927 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from To record ....., 19....., to ....., 19.....,

that I last saw h[illegible] alive on April 10, 1927,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

2 weeks (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

April 14, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Wayfield Rd) Date of Burial April 18 1927

20 UNDERTAKER Leonard J. Ruck ADDRESS Seffon ave

Pat

very important. See INSTRUCTIONS ON BACK OF CERTIFICATE.

S... 1-12-23—M&T—500 Bks.

E 21257 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital, Baltimore, Md. REGISTERED NO. 118-002

CITY OF BALTIMORE: (No. 4-1 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alma Lewis.

(a) RESIDENCE NO. Blossom, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. C. Lewis

6 DATE OF BIRTH (month, day, and year) Nov. 5 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	48	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lunenburg, Co. Va.

PARENTS

10 NAME OF FATHER John H. Elder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Smithfield Va.

12 MAIDEN NAME OF MOTHER Alma Marion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss.

14 Informant E. C. Lewis (Address) Blossom Va.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

E. C. Lewis on Tax Rec.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1927 to April 15 1927.

that I last saw h... alive on April 15, 1927.

and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis, and intestinal obstruction

(duration) yrs. mos. 18 da.

CONTRIBUTORY (Secondary) Intestinal obstruction.

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Blossom, Va.

Did an operation precede death? Yes Date of 4-6-27

Was there an autopsy? No. 4-18-27

What test confirmed diagnosis? Operation.

(Signed) Allen W. Kelly, M. D.

, 19 (Address) Mercy Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blossom Va.

DATE OF BURIAL 4/16 ?

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 W North Ave.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21258

CERTIFICATE OF DEATH.

× 44 E 21258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-4 Ward)

2-FULL NAME Ulysses S. Young

(a) RESIDENCE NO. Lincoln Highway St. Co Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~	Col	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Ada Young

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years	Months	Days	IF LESS than 1 day....hrs. or....min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Ulysses Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Florence Rudas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 | 14 | 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to April 14, 1927, that I last saw him alive on April 14, 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

Pneumonia

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of March 19, 1927

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) Laurence D Smith, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orange N.J. Date of Burial 4-16-27

20 UNDERTAKER Jas. W. Skinner ADDRESS 1625 E. Madison St

very important. See INSTRUCTIONS on back of Certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21259

E 21259

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 418 N. Shuter St. 14-27 Ward)

2-FULL NAME Flora Louise Roberts

(a) RESIDENCE NO. 418 N. Shuter St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or race	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18th 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	0	14/13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Sim Roberts

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New Orleans La

12 MAIDEN NAME OF MOTHER Alice Bantum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Elbert W. Thomas

(Address) 418 N. Shuter St

15 Filed C. HAMPSON JONES, M. D. Registrar

6 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 14 1927, to April 14, 19 27,

that I last saw h[illegible] alive on April 14, 19 27,

and that death occurred, on the date stated above, at 8 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 6 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — Date of Burial April 16 1927

20 UNDERTAKER Mrs. Kate R. Williams — ADDRESS 322 N. Schroeder St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

21260

HEALTH DEPARTMENT—CITY OF BALTIMORE

21260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1030 N. Monroe ST. 16-22-162 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Emry

(a) RESIDENCE NO. 1030 N Monroe ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 4-12-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Mr. Emry

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Magdalena Malinda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M. W. Emry

(Address) 1030 N Monroe St

15 Filed APR 16 1927 C. HAMPSON JONES, M. D.

By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-12- 1927, to 4-15 1927,

that I last saw h[illegible] alive on 4-14 1927

and that death occurred, on the date stated above, at 5 4 m

The CAUSE OF DEATH* was as follows:

Delayed asphyxia

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thyroid Surgeon

(Signed) W. A. Pull, M. D.

Apr 15, 1927 (Address) Emmitsburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden DATE OF BURIAL Apl 16 1927

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut St

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21261

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 509 Radnor Av 27-48 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Nonney

(a) Residence No. 509 Radnor Av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Nonney

6-DATE OF BIRTH (month, day and year) Feb 1-1853

7-AGE 74 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Denal R. O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Hanna O'Sullivan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Nellie Nonnell

(Address) 509 Radnor H.Vs.

15- Filed 4 6 1927 C. HAMPSON JONES, M. D. Registrar. Per AAH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-14-27

17- I HEREBY CERTIFY, That I attended deceased from April 1 1927 to April 14 1927

that I last saw h alive on April 13 1927

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chr. Int. Nephritis

Chr. Myocarditis Asthma

(Duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) G. L. Bishop M. D.

April 15, 1927 (Address) 501 Shinda Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral | DATE OF BURIAL. 4-16-1927

20-UNDERTAKER. H. Brauning & Son ADDRESS 5 17 N Schroeder St

Spec. 1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21262

CERTIFICATE OF DEATH.

E 21262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 N. North Ave ST., 15-68 WARD)

2-FULL NAME Mrs. Henrietta Forsythe

(a) RESIDENCE NO. Woodlawn, Md., (or Rural Route No. 1, Box 24, 27 ST., WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas Forsythe

6 DATE OF BIRTH (month, day, and year) May 31, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Samuel Flemmyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Annie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mrs. Euphemy Claridge (Address) Govans Road & Hamilton Hill

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14- 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-9- 1927, to 4-14- 1927.

that I last saw h... alive on 4-14- 1927.

and that death occurred, on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Endocarditis (Aortic)

(duration) Indefinite Several yrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmerich Lovell M. D.

, 19 (Address) 3705 Liberty Hts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL April 16 1927

20 UNDERTAKER Nelson Cook ADDRESS 502 E. North Ave.

FROM A very important

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21263

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21263

CERTIFICATE OF DEATH.

59-002

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2730 E Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bamberger

(a) Residence No. 2730 E Chase St St., 8 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 13 1927

7-AGE. — yrs. — mos. — ds. If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Edwin Bamberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Violet A Hiener

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant) Edwin Bamberger

(Address) 2730 E Chase St

15- Filed APR 16 1927 C. HAMPSON JONES, M. D. Registrar. Per RPH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 13 1927

17- I HEREBY CERTIFY, That I attended deceased from April 13 1927 to April 13 1927

that I last saw him alive on April 13 1927

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation (Cause)

5 months Foetus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. T. Herzog M. D.

Apr 15 1927 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem DATE OF BURIAL, 4/16/27

20-UNDERTAKER, Wm Cook ADDRESS 502 E Lanvale

Spec.–7-17-26—A Co.—200 Bks.

Dr Duvall 1817 N Fulton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21264

CERTIFICATE OF DEATH

90 E 21264

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 N. Fulton Ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett L Parlett

(a) RESIDENCE NO. 1121 N. Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. O Parlett

6 DATE OF BIRTH (month, day, and year): March 24, 1843

7 AGE: Years 84 Months 0 Days 19

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: John Slaughter

11 BIRTHPLACE OF FATHER (City or town): Pa

(State or country)

12 MAIDEN NAME OF MOTHER: Hannah Cromwell

13 BIRTHPLACE OF MOTHER (city or town): Pa

(State or country)

14 Informant: H. L. Parlett

(Address) 1121 N Fulton Ave

15 Filed C. HAMPSON JONES, M. D.

APR 16 1927 Registrar

For RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 19 27, to Apr 13, 19 27, that I last saw h[illegible] alive on Apr 13, 19 27, and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 5 yrs. 12 hours ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) about 3 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Duvall M. D.

(Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Elm — Date of Burial: Apr 16 1927

20 UNDERTAKER: W. Cook — ADDRESS: 501 E North Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21265

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21265

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 N. Lombard St. 18-29 Ward)

2-FULL NAME Harry L. Johnson

(a) RESIDENCE NO. 1081 N Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 57 Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer): 057

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baeto

PARENTS

10 NAME OF FATHER: Littleton F. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Augusta Dommaer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Anna E. Johnson

(Address): 4503 Reisterstown Road

15 Filed ..... 19 ..... C. HAMILTON JONES

16 1927 Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Body found dead Apr. 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken Neck

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fell down Steps

(duration) ..... yrs. ..... mos. ..... ds.

Signed: Thos. B. Hoston M. D.

(Coroner)

Apr 15 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where did disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial: Apr 16 1927

20 UNDERTAKER: Wilcom Cook ADDRESS: 507 E Lock Ave.

Spec.–7-17-26—A Co.—200 Bks.

21266

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 21266

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1654 Appleton St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas M Shamberger

(a) RESIDENCE NO. 1654 Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lucinda Shamberger

6 DATE OF BIRTH (month, day, and year) Dec 24 – 1845

7 AGE	Years	Months	Days 21	IF LESS than 1 day ..... hrs. or ..... min.
	81	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Shamberger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Markey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hiram Shamberger

(Address) 1654 Appleton St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15 – 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov – 20 – 1926 to Apr 15 – 1927

that I last saw him alive on Apr 15 – 1927

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis acute,

Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Brantley Gunch M. D.

1927 (Address) 1900 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Grace Church, Balto Co	Apr 18 1927
20 UNDERTAKER Edward Tipton	ADDRESS Hampstead Md

very important. See instructions on back of certificates.

G 1927

Spec.—1-10-21—M&T—1500 Bks.

E 21267

HEALTH DEPARTMENT—CITY OF BALTIMORE E 21267

CERTIFICATE OF DEATH.

100 30 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Wilmer St. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Paul Scott

(a) RESIDENCE NO. 933 Wilmer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year): Mch 24/27

7 AGE: Years — Months — Days 20 — If LESS than 1 day, hrs. or min. 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Wm Paul Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Annie Gouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Arthur J. Cockey Friend

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to April 13, 1927, that I last saw him alive on April 13, 1927, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — DATE OF BURIAL: April 16 19 27

20 UNDERTAKER: Leonard Waller — ADDRESS: 304 Myrtle Ave

Spec.—12-9-25—A Co.—200 Bks.

21268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21268

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1645 Jackson St. 24-24 WARD)

2-FULL NAME August Niemann

(a) RESIDENCE NO. 1645 Jackson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura A. Niemann

6 DATE OF BIRTH (month, day, and year) Mar. 28-1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER M. Schmaltz

13 BIRTHPLACE OF MOTHER (city or town) Unk

(State or country)

14 Informant Mr. Wagam (Son)

(Address) 1645 Jackson.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By RKM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14/1927 19

17 I HEREBY CERTIFY, That I attended deceased from Apr 9 1927, to Apr 14, 1927,

that I last saw h.. alive on Apr 14, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

, 19 (Address) 1641 Jackson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem Date of Burial 4/16 1927

20 UNDERTAKER I. Frew McCully ADDRESS 130 E. Fort

very important. See instructions on back of certificate

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21269 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21269

CERTIFICATE OF DEATH.

74-001

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 939 N. Washington St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Kauckey.

(a) Residence No. 939 N. Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 3[illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married.

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Frances Kauckey

6-DATE OF BIRTH (month, day and year) March 8. 1850

7-AGE. 77 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Tailor. 80

(b) General nature of industry, business, or establishment in which employed (or employer). At Home.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Bohemsa.

PARENTS.

10-NAME OF FATHER. Anton Kauckey.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohema.

12-MAIDEN NAME OF MOTHER. Not Known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohema.

14- (Informant) Frances Kauckey.....
(Address) 939 N. Washington St.

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 15 27

17. I HEREBY CERTIFY, That I attended deceased from 3827 19 27 to April 15 19 27

that I last saw h[illegible] alive on April 15 19 27

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Kaufmann M. D.

(Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Hill. DATE OF BURIAL. April 18, 1927.

20-UNDERTAKER. August Pasek. ADDRESS 2406 Eastland Ave.

Cor—12-9-25—A Co—300 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21270

CERTIFICATE OF DEATH.

E 21270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. In City Hospital Dundalk Md St., 7-9 Ward)

2-FULL NAME William Zeller

(a) RESIDENCE NO. 627 N. Castle St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Zeller

6 DATE OF BIRTH (month, day, and year) Jan. 15/53

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butscher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C. Hohman & Sons

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER William Zeller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Agnes Zeller

(Address) 627 N. Castle St. M. D.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14th. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows: R. R. Acc.

Multiple Fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

Apr 15 27 (Signed) H. C. Hayes (Coroner) M. D.

Apr 15 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cem. Date of Burial 4/16/27

20 UNDERTAKER Philips & Herwig ADDRESS 2016 Orleans St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21271

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21271

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Md. Gen. Hosp.

CITY OF BALTIMORE: (No.) 16-68 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Abbott

(a) RESIDENCE NO. 2513 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER David Abbott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Jos. Hanna.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Hosp. Record.
(Address)

15 FILED 6 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/30, 1927, to 4/13, 1927.

that I last saw him alive on 4/13, 1927.

and that death occurred, on the date stated above, at 3-13 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis with Peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 3/30/27

Was there an autopsy? No

What test confirmed diagnosis? Operation —

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4-16- 1927

20 UNDERTAKER Patrick A. Nannan

ADDRESS 3707 Fremont Ave.

Spec.—1-12-23—M&T—500 Bks.

E 21272

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21272

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Barclay. at 47-50 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora. Prosser.

(a) RESIDENCE NO. 2124 Barclay ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: H. C Prosser

6 DATE OF BIRTH (month, day, and year): Sept. 24. 1882

7 AGE: Years: 44 Years; Months: 6; Days: 20; If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Lacey.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mrs Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: H. C Prosser

(Address): 2124 Barclay

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

Day

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-14 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1926, to 4-14, 1927.

that I last saw h alive on 4-13, 1927

and that death occurred on the date stated above, at 10 A m

The CAUSE OF DEATH was as follows:

Carcinoma of Breast
Carcinoma of Pelvis
(metastasis)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of about 1925

Was there an autopsy? No

What test confirmed diagnosis? Clinical X ray

(Signed) [illegible]

4-14-27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 4/19 1927

20 UNDERTAKER: George Ruth

ADDRESS: 1765 Hartford Ave

Spec.—1-10-21—M&T—1500 Bks.

E 21273

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Mc Donough St. 7-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Coard

(a) RESIDENCE NO. 807 Mc Donough St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of Annie Coard

6 DATE OF BIRTH (month, day, and year) Feb 28, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Sumter S.C.

PARENTS

10 NAME OF FATHER Edward Coard S.C.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Viola Canty S.C.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Appell Coard (Brother) 807 Mc Donough St

15 Filed 6 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927, to April 14, 1927, that I last saw h[illegible] alive on April 14, 1927, and that death occurred, on the date stated above, at 12 00 A.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

4/14, 1927 (Address) 1429 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany Cem DATE OF BURIAL April 16 1927

20 UNDERTAKER Daniel Easton ADDRESS Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 21274 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21274

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 925 N. Carey ST. 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Gibson

(a) RESIDENCE NO. 925 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Gibson

6 DATE OF BIRTH (month, day, and year) Nov 23-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	21	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self. 037

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Grundy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Taylor (Address) 925 N. Carey

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to April 14, 1927, that I last saw h alive on April 14, 1927 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation ?

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Wm H Wright M. D.

April 15, 1927 (Address) 1209 Pretsman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 16 1927

20 UNDERTAKER Daniel Easton ADDRESS Va ave

TION IS VERY IMPORTANT

G 1927 Pat

Cor.—12-9-25—A Co.—200 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21275 66 E 21275

CERTIFICATE OF DEATH.

REGISTERED NO. 4277

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Rear 1300 Block W. Baltimore St. (Ward)

2-FULL NAME Eliza Cook

(a) RESIDENCE NO. 313 N. Parish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jerry Cook

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Jerry Cook

(Address) 313 N. Parish St

15 Filed C. HAMPSON JONES, M. D. Registrar

6 1927 By

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence of (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure due to senile Pleuritis

(Interval) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Interval) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

Apr 16 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion Date of Burial April 18 1927

20 UNDERTAKER Joseph A Lively ADDRESS 409 N Mont St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21276

CERTIFICATE OF DEATH.

129 E 21276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 N. Pamish St. 19-27 Ward)

2-FULL NAME Hattie Williams

(a) RESIDENCE NO. 412 N. Pamish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced (or) WIFE of Will Williams

6 DATE OF BIRTH (month, day, and year) Aug 17 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
49	50	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer 0

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER E Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mable Williams

(Address) 412 N. Pamish

15 Filed ... 19 ... Registrar

1927 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1927 to 4-13, 1927, that I last saw h alive on 4-13, 1927, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson M. D.

4/14, 1927 (Address) 1808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion — Date of Burial April 16 1927

20 UNDERTAKER Joseph A. Lively — ADDRESS 409 W Mount Street

very important. See instructions on back of

Spec.—1-12-23—M&T—500 Bks.

(Snyder)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21277

CERTIFICATE OF DEATH.

44 E 21277

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ. Hospital ST. 15-68 WARD)

2-FULL NAME Henry Snyder

(a) RESIDENCE No. 2663 North Ave - W. ST., ... Belair WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Sept. 3 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Stone Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Peter Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Kinzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry E. Snyder

(Address) 2663 N. North Ave

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-8-1927 to 4-10-1927

that I last saw h[illegible] alive on 4-10-27

and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Primary Carcinomatosis

Primary growth in Stomach

(duration) 1 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1-10-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauden Park

DATE OF BURIAL April 18, 1927

20 UNDERTAKER Frank A. Fink

ADDRESS 915 E. Fayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21278

CERTIFICATE OF DEATH.

188-002

E 21278

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. 15-61 Ward)

2-FULL NAME Ignatius Smith

(a) RESIDENCE NO. 2207 Rosslyn Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Smith

6 DATE OF BIRTH (month, day and year) July 30, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 016

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor & Builder

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md

PARENTS

10 NAME OF FATHER Michael Smith

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md

14 Informant Beatrice R. Smith

(Address) 2207 Rosslyn Ave

15 Filed 3 1927 By HAMPSON JONES, M. D. Registrar

For

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of femur. (accidental) less than 1 day

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

April 15, 1927 (Address) 7807 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial 4-18 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

Spec.—5-19-13—M. & T.—500 Bks.

E 21279 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21279

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3035 St Paul St. 12-50 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ann Stembler

(Residence in Baltimore: No.) 3035 St Paul St.

65 yrs., ~~mos. ds.~~

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (Write the word.): Widow

6-DATE OF BIRTH: November 6th, 1856 (Month) (Day) (Year)

7-AGE: 70 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Norfolk Va

PARENTS.

10-NAME OF FATHER: Theodore Nathan

11-BIRTHPLACE OF FATHER (State or Country): Philadelphia Pa.

12-MAIDEN NAME OF MOTHER: Mary Susan Davis

13-BIRTHPLACE OF MOTHER (State or Country): Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Rebecca Heman

(Address) 3035 St Paul St.

15- Filed R 16 1927 19... C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 14th (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3rd 1927. to April 13th 1927. that I saw her alive on April 13th 1927. and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) 3 yrs. ~~mos. ds.~~

CONTRIBUTORY (Secondary) Chronic Rheumatism and Mitral Stenosis (Duration) 5 yrs. mos. ds.

(Signed) Robt. H. L. Lumpkin M. D.

April 14th 1927 (Address) 11 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet — DATE OF BURIAL, April 16, 1927

20-UNDERTAKER George J. Smith — ADDRESS 532 Hollins

Spec.—12-9-25—A Co.—200 Bks.

E 21280

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 21280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 96 27 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bordley

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

Filed 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1927

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to April 11, 1927, that I last saw him alive on April 11, 1927, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency (duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Smith M. D.

April 26 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND APR 28 1927

Very important. See instructions on back of this [illegible]

Spec.—12-9-25—A Co.—200 Bks.

E 21281

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21281

CERTIFICATE OF DEATH.

31

5-8

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. C. B. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Green

(a) RESIDENCE NO. 152 East st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Green

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Fred Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary J. Bennet

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant Hospital Records

(Address)

C. HAMPSON JONES, M. D.

15 Filed 19 Registrar

6 1927 Per 1256 Ard

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 30 19 27, to April 13, 19 27,

that I last saw h im alive on April 13, 19 27,

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Elwood

What test confirmed diagnosis?

(Signed) W. Kellam, M. D.

4-13-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Interred and buried in Loudon Cemetery 4-20-27

20 UNDERTAKER ADDRESS

Edward Bowen 1631 Orleans St.

Spec.—12-9-25—A Co.—200 Bks.

E 21282

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 21282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hosp. St. 26-37 Ward

2-FULL NAME John Lobuda -

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. None St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1877

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant

(Address)

15 6 1927 C. HAMPSON JONES, M. D. Registrar

1265 For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1927 to April 13, 1927

that I last saw him alive on April 13, 1927

and that death occurred, on the date stated above, at 5.55 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND.

Commissioner of Health. APR 16 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21283 E 21283

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General St. Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice McCleary

(a) RESIDENCE NO. 1711 Darley Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Wm. V. McCleary

6 DATE OF BIRTH (month, day, and year): Sept. 26, 1883

7 AGE — Years: 43 — Months: 6 — Days: 19 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Reardine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Cramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Hospital Records

(Address)

15 6 1927 C. H. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-15 1927

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1927, to April 15, 1927,

that I last saw h-er alive on April 15, 1927,

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Hypertension. arteriosclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A Lowe M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: Apl. 19 1927

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1944 W. North Ave

Spec.—12-9-25—A Co.—200 Bks.

E 21284

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21234

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. 21-55

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Ganter

(a) RESIDENCE NO. 5404 Park Hts Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Ganter

6 DATE OF BIRTH (month, day, and year): Jan 13 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Charles Sulzbacher

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Lucian Schultz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Friends

(Address)

15 Filed ..... 19 .....

Per ..... Registrar

6 1927 C. HAMPSON JONES, M. D.

ARH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 1927, to Apr 15, 1927,

that I last saw h[illegible] alive on Apr 15, 1927,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, hypertension

chronic, 4 pleurisy (duration) 4 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Milton Aronson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Apr 18 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

75-001

E 21285

CERTIFICATE OF DEATH

E 21285

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Villax Ave St. Raspeberg Ward 27-42)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Schnatz

(a) RESIDENCE NO. 7 Villax Ave St. Raspeberg Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul H. Schnatz

6 DATE OF BIRTH (month, day, and year) Mar. 8. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	62	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) New Jersey

(State or country)

PARENTS

10 NAME OF FATHER John G Franke

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Lapps

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Miss Gertrude Schnatz (Daughter)

(Address) 7 Villax Ave. Raspeberg.

15 Filed C. HAMPSON JONES, M. D.

Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1927

17 I HEREBY CERTIFY, That I attended deceased from 1924, 19..., to April 15, 1927.

that I last saw h... alive on ..., 19...

and that death occurred, on the data stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

T. Hemiplegia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gertrude Schnatz, M. D.

Apr. 16. 1927 (Address) Overlea, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	Apr. 19. 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1710 Fleet St.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21286 E 21286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1107 Argyle Ave ST. 1-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Lyles

(a) RESIDENCE NO. 1107 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md

PARENTS

10 NAME OF FATHER McCoon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Thomas (Address) 1926 N. Eutaw St.

15 Filed 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to April 13, 1927, that I last saw h[illegible] alive on April 13, 1927, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) yrs. mos. 2 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) H. Tabley, M. D.

, 19 (Address) 1926 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem DATE OF BURIAL 4/16 27

20 UNDERTAKER Samuel C. Wesley ADDRESS 1 E Biddle

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21287

E 21287

101-001

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE. (No.) 824 N. Carey St. (Ward) 16-2-3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Sekk

(a) RESIDENCE NO. 824 N. Carey St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zelma Sekk

6 DATE OF BIRTH (month, day, and year) Oct 23-1891

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
35	36	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Denton (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Celice

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Zelma Sekk (Address) 824 N Carey St

15 Filed _____ 19 _____ Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11 1927 to April 14 1927

that I last saw h[illegible] alive on April 14 1927

and that death occurred, on the date stated above, at 5.30 P m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (Secondary)

0 (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) John E Stewart M. D.

4/15 19 27 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem 4/17 Date of Burial 27

20 UNDERTAKER Samuel Hunsley ADDRESS 1[illegible]

very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21288

CERTIFICATE OF DEATH

129 E 21288

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital 16-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Minor

(a) RESIDENCE NO. 1412-Reggrad St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 869

7 AGE: 58 Years 59 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Dan Mills

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Katie Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harriet Coates

(Address) 532 N. Calvert

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-23-1927, to 4-13-1927, that I last saw h[er] alive on 4-12-1927, and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

Light Lesion Lung

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Grimes, M. D.

4-13-1927 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: Nov. 16 1927

20 UNDERTAKER: Sam'l. H. Chase & Son. — ADDRESS: 1400 Madison

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 21289

REGISTERED NO. E 21289

E 21289

1-PLACE OF DEATH

City of BALTIMORE: (No. 1417 E. Preston St St. 5-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norma LaVauris Plowman

(a) RESIDENCE NO. 1417 E. Preston St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) March 13/25

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Silae G. Plowman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Aberdeen, Md

12 MAIDEN NAME OF MOTHER Alice B. Coponi

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Aberdeen, Md

14 Informant Silas G. Plowman

(Address) 1417 E. Preston St.

15 Filed] 1927 C. HAMPSON JONES, M. D. Registrar

Per K.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Hemorrhage

(Rt. sided paralysis 1 yr ago following measles & pneumonia)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Carey M. D.

(Coroner)

19 (Address) 4/16/27 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baker Cemetery Harford Co Md 4-17-27 Date of Burial

20 UNDERTAKER Henry Herring Sons ADDRESS Aberdeen Md

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21290

CERTIFICATE OF DEATH.

4 90

E 21290
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 75-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Quirk

(a) RESIDENCE NO... Emmitsburg Md. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 ~~Single, Married~~, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not given

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer "

9 BIRTHPLACE (city or town) ... not given
(State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Sister - Mrs Mary Daugherty
(Address) Emmitsburg Md

15 Filed PR 17 1927 H. HARRISON JONES, M. D. Registrar
By LK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1927, to 4-16, 1927,

that I last saw her alive on 4-16, 1927,

and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following cerebral hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardio-renal disease with hypertension

(duration) ? yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Theron Hunter, M. D.

4/16, 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmitsburgh Md

DATE OF BURIAL: 4-18-27.

UNDERTAKER: Robt L. Topper

ADDRESS: Emmitsburgh Md.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21291

CERTIFICATE OF DEATH.

90 E 21291

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1011 Grauby. St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josef Vilciauskas

(a) RESIDENCE NO. 1011 Grauby St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1861

7 AGE 66 Years — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Talor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania

(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant John Grebliauckas

(Address) 423 S Paca St.

15 Filed APR 7 1927 W. HAMPTON JONES, M. D.

Per Registrar

very important. See instructions on back of sheet

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

April 16 27 (Signed) C. C. Grader M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: APRIL 18, 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 21292

REGISTERED NO.

E 21292

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto city Hosp St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lodie Avriss

(a) RESIDENCE NO. 3340 Montebello ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anderson.

6 DATE OF BIRTH (month, day, and year): Unknown. 1880

7 AGE: Years 47 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jeff Harris

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Laura

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Indiana

14 Informant (Address): Jeff Harris 3340 Montebello ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927 to April 14, 1927

that I last saw her alive on April 14, 1927

and that death occurred, on the date stated above, at 3-55 m.

The CAUSE OF DEATH* was as follows: Pneumonia Chronic

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Maxwell, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Date of Burial April 1927

20 UNDERTAKER: Mrs. A. G. Elbert ADDRESS 1117 Ashland Av.

Very Important. Not to be detached.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21293

CERTIFICATE OF DEATH.

129 E 21293

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2405 Mace St (WARD) 17-51

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Armstrong

(Residence in Baltimore: No. 2405 Mace St; St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb. 16, 1883 (Month) (Day) (Year)

7-AGE, 44 yrs. 1 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), VA

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Armstrong

(Address) 2405 Mace st

15- APR 17 1917 HAMP. JONES, M. D.

Filed Registrar.

Per Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1917, to April 14 1917, that I saw her alive on April 14 1917, and that death occurred, on the date stated above, at 11.46 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis Complicated with Heart Failure

(Duration) 1 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 5 yrs. 6 mos. ds.

(Signed) G. L. Hall M. D.

4/17 1917 (Address) 426 E. 23 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Calvary DATE OF BURIAL, April 16, 1917

20-UNDERTAKER Mrs. A. J. Elliott ADDRESS 1920 Aisquith

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21294

E 21294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Carl Smith

(a) RESIDENCE NO. Hanover Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) W. Va.

(State or country)

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) W. Va.

(State or country)

12 MAIDEN NAME OF MOTHER Attie Summers

13 BIRTHPLACE OF MOTHER (city or town) W. Va.

(State or country)

14 Informant Records

(Address)

15 Filed APR 17 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15 1927, to Apr. 16 1927, that I last saw her alive on Apr. 16 1927, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Brain tumor

with a history of (duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mns. — ds.

18 Where was disease contracted if not at place of death? Patient's home

Did an operation precede death? yes Date of April 16, 1927

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) George B. Turner, M. D.

4, 17, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edon Va

Date of Burial 4/17/27

20 UNDERTAKER Joseph Lahrens

ADDRESS 721 Bway

Spec.—12-9-25—A Co.—200 Bks.

E 21295

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Lear

(a) RESIDENCE NO. Rockingham, N. C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1880

7 AGE Years 47 Months Days 26. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hosiery Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Benjamin Lear

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Jane Tuca

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Mrs Hinson (Pt's sister)

(Address)

Filed 4-17-1927 19 JAMES H. JONES, M. D.

Registrar

R 17 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 29th 1927, to April 17th 1927, that I last saw h[er] alive on April 17th 1927, and that death occurred, on the date stated above, at 12.50 A. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Cancer)

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/30/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) George G. Finney, M. D.

4/17/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamlet N C

Date of Burial 4/17/1927

20 UNDERTAKER Joseph Arens

ADDRESS 221 Bway

very important. See instructions on back

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21296

CERTIFICATE OF DEATH.

E 21296

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 923 So. Second St., 76-1 Ward)

2-FULL NAME Mildred Mills

(a) RESIDENCE NO. 923 So. Second St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8, 31- 1918

7 AGE — Years: 8 | Months: 7 | Days: 16. | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Columbia

(State or country): So. Carolina

PARENTS

10 NAME OF FATHER: Toney Mills

11 BIRTHPLACE OF FATHER (city or town)

(State or country): S. C.

12 MAIDEN NAME OF MOTHER: Hester Aiken

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): S. C.

14 Informant: Lillie Ripley

(Address): 923 So. Second St.

Filed: APR 17 1927 C. HAMPSON JONES, M. D. Registrar

By: R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1927, to Apr 16, 1927, that I last saw h.. alive on April 15, 1927, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) J. Edward Fisher, M. D.

Apr 16 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia S.C. Date of Burial: Apr 17 1927

20 UNDERTAKER: Robert E. Williams ADDRESS: 1515 McCulloh St

Spec.–7-17-26—A Co.—200 Bks.

Dr Hubert, Lafayette & Arlington Aves

HEALTH DEPARTMENT—CITY OF BALTIMORE

21297

74-001

CERTIFICATE OF DEATH

E 21297

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 Smith St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand C Bauer

(a) RESIDENCE NO. 616 Smith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adeline Bauer

6 DATE OF BIRTH (month, day, and year): May 30, 1851

7 AGE: Years 75 Months 10 Days 15

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs Annie Ruppel

(Address): 2206 McKean Ave

Filed APR 7 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 15 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1927, to April 15-15, 1927, that I last saw him alive on April 15—, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Cerebral)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? None Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. H. Bubert, M. D.

April 16 1927 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary

Date of Burial: Apr 19 1927

20 UNDERTAKER: J M Cook

ADDRESS: 502 E Lombard

Spec.—7-17-26—A Co.—200 Bks.

Dr Cof. Fulton & Lombard Sts

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21298 — 129 — E 21298

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2534 W. Lombard St. 90-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A Pease

(a) RESIDENCE NO. 2534 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Pease

6 DATE OF BIRTH (month, day, and year): Feb 8 1849

7 AGE: Years 78 Months 7 Days 7 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balt (State or country) Md

PARENTS

10 NAME OF FATHER: Francis Pease

11 BIRTHPLACE OF FATHER (City or town): Balto (State or country) Md

12 MAIDEN NAME OF MOTHER: Richmond

13 BIRTHPLACE OF MOTHER (city or town): Balto (State or country) Md

14 Informant: Lewis R Reagan (Address) Lutherville Md

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

APR 17 1927 Per

very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1921 to April 12 1927

that I last saw him alive on April 12 1927

and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chas A Cary M. D.

4/16 1927 (Address) 543 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney — Date of Burial: Apr 18 1927

20 UNDERTAKER: H J Cook — ADDRESS 502 E Madison

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21299

CERTIFICATE OF DEATH.

74-001

Registered No. E 21299

1-PLACE OF DEATH

City of BALTIMORE: (No. 1400 Dellwood Ave. St., 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Rusbaum

(Residence in Baltimore: No. 1400 Dellwood Ave. St.) (If under 1 yr., 36 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Sept. (Month) 1 (Day) 1885 (Year)

7-AGE: 41 yrs. 7 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Yarn tester
(b) General nature of industry, business, or establishment in which employed (or employer): W. Vern Woodberry Mills

9-BIRTHPLACE (State or Country): Carroll Co. Md.

PARENTS

10-NAME OF FATHER: Israel Rusbaum

11-BIRTHPLACE OF FATHER. (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Rider

13-BIRTHPLACE OF MOTHER. (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Minnie R. Rusbaum

(Address): 1400 Dellwood Ave

15- APR 17 1927

Per [illegible] HAMPTON JONES, M. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April 15 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) died that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

4/16 1927 (Address) 3672 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Mem. Frederick Md. DATE OF BURIAL: April 18 27

20-UNDERTAKER: Horace G. Burgee ADDRESS: 363 Fells Road.

ree.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21300

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St. Joseph's Hospital ST. 10-14 WARD)

2-FULL NAME Infant E. Sappington

(a) RESIDENCE NO. 818 E. Eager Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

V 54-003

154 E 21300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

a If married, widowed, or divorced
HUSBAND of
(a) WIFE of

DATE OF BIRTH (month, day, and year) April 15, 1927

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	9 hrs

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Edw. C. Sappington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Hilda Pauline Brent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: St. Joseph Hospital

(Address): Elm & Cathedral Sts

15 Filed APR 17 1927 Per R.K. H. HADDOX JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/1927

17

I HEREBY CERTIFY, That I attended deceased from 4/16, 1927, to 4/16 1927

that I last saw him alive on 4/16, 1927

and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Congenital umbilical

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Exhaustion & Toxemia

(duration) yrs. mos. 6 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/16/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H R. McCamish M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: April 19 1927

20 UNDERTAKER: Elmer W Conklin — ADDRESS: 124 E Eager St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21301 — 117 — E 21301

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST. 14-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Sirwan

(a) RESIDENCE NO. 613 Edmondson Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Sirwan

6 DATE OF BIRTH (month, day, and year) - 1865

7 AGE: Years 62 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jim Black.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Linn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nicholas Sirwan

(Address) 613 Edmondson Ave

15 Filed APR 7 1927 HAMPSON JAMES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/9, 1927, to 4/15, 1927, that I last saw h 4 alive on 4/15 1927 and that death occurred, on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows: Cerebritis (Gas)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 4/13/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 4/18 1927

20 UNDERTAKER J. J. Baker & Sons ADDRESS 1318 Light St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21302

E 21302

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1708 Oak (St.) 17-51 (Ward)

2-FULL NAME James J. Ryan

(a) RESIDENCE, NO. 1708 Oak St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Mollie Corrigan

6 DATE OF BIRTH (month, day, and year) Feb 10, 1867

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Patrolman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Owen Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Owen Ryan 1708 Oak St.

15 Filed APR 17 1927 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927 to April 15 1927.

that I last saw him alive on April 15 1927

and that death occurred, on the date stated above, at 8.30 ~~P~~ m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) one yr. mon. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4-17-27 (Address) 320 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cem

DATE OF BURIAL: 4/19 1927

20 UNDERTAKER: J. J. Lahey Sons

ADDRESS 1316 Eight

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 21303

CERTIFICATE OF DEATH.

E 21303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3104 Auchentorolly Terrace WARD 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Harig

(a) RESIDENCE No. 3104 Auchentorolly Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 20. 1859

AGE	Years	Months	Days	If LESS than 1 day, brs. or min.
	67	8	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Secretary + Treasurer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Zell Motor Co.

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: August H. Harig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Antje Campen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Miss Katherine Harig (Sister)
(Address) 3104 Auchentorolly Terrace

Filed APR 17 1927 HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D. (Coroner.)

4/16, 1927 (Address) 1512 Riverdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Apr. 18 1927
20 UNDERTAKER: Henry Sander & Sons Inc	ADDRESS: 1710 Fleet St.

ec.—1-12-23—M&T—500 Bks.

21304

HEALTH DEPARTMENT—CITY OF BALTIMORE

21304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 430 St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Baer

(a) RESIDENCE NO. Rodgers ave. Elliott City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1899

7 AGE: Years 28; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Neneon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Baer (Address): Elliott City Md

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/16/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/13/27, 19... to 4/16/27, 19...

that I last saw him alive on 4/16/27, 19...

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia-Left Base

(duration) ... yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Heart Failure

(duration) yrs. 2 hours mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery

DATE OF BURIAL: April 18 1927

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

T 1927 C. HAMPTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 21305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 21305

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 4-30 Ward)

2-FULL NAME Thos. Tuppe

(a) RESIDENCE NO. 403 Lemmon St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Underwood

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	4	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Ethel Brown

(Address) 516 W Baltimore St

15 Filed 7 1927 C. HAMPSON JONES, M. D.

Registrar

at Hospital

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) ____ yrs. ____ mos. 1 ds.

April 14 (Signed) C C Yates (Coroner) M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem. Date of Burial 4/18 1927

20 UNDERTAKER Mrs Fred Hoop ADDRESS 406 N Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21306

CERTIFICATE OF DEATH.

90

E 21306
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2808 E. Orleans St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry H. Owens

(a) RESIDENCE NO. 2808 E. Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Owens

6 DATE OF BIRTH (month, day, and year) Oct 1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dispatcher

(b) General nature of industry, business, or establishment in which employed (or employer) Automobiles

(c) Name of employer P.O.Dept

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Henry Owens

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Josephine Owens

(Address) 2808 Orleans St.

Filed APR 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Owens, M. D. (Coroner)

4/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial Apr. 18 1927

UNDERTAKER H. Mowen ADDRESS 3008 Ellis St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21307

21307

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. (WARD)

2-FULL NAME James D. Jett

(a) RESIDENCE NO. 1827 W Lexington St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): May 19 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John D. Jett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Laura Helen Ashburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Hospital Records

15 Filed APR 18 1927 Registrar C. HAMPTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/17 1927 to 4/17/27 1927, that I last saw him alive on 4/17/27 1927, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Septicemia, Streptococcus hemolyticus

(duration) About yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. 1/3 mos. Hours

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/13/27

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/17 1927 Address [illegible]

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lexington, Va. DATE OF BURIAL: Apr. 19 1927

20 UNDERTAKER: Joseph B. Cook ADDRESS: 103 N. Eutaw St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21308

CERTIFICATE OF DEATH

90

E 21308

REGISTERED NO. 4-20

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Butler

(a) RESIDENCE NO. 517 Forster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 1904

7 AGE: 22 Years 8 Months 9 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Ft Dodge

9 BIRTHPLACE (city or town): Ft Dodge

(State or country) md

PARENTS

10 NAME OF FATHER: Jas. Thomas

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Emma Shillington

13 BIRTHPLACE OF MOTHER (City or town): Md.

(State or country)

14 Informant: Jas. Johnson

(Address) 517 Forster St.

15 Filed APR 18 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17 19 27 to Apr. 15 19 27

that I last saw h alive on Apr. 15 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows

Acute Mitral insufficiency.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Carr M. D.

Apr. 18 1927 (Address) 515 Forster St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft Dodge Iowa Date of Burial 4/18 19

20 UNDERTAKER: Samuel Brusley ADDRESS

Very Important: See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21309

CERTIFICATE OF DEATH.

43

E 21309

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1-1 ST., WARD)

2-FULL NAME Mrs. John Johns

(a) RESIDENCE NO. 3125 Dillon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johns

6 DATE OF BIRTH (month, day, and year) Nov. 20. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Johns

11 BIRTHPLACE OF FATHER (city or town) South Wales. Cumb.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Williams

13 BIRTHPLACE OF MOTHER (city or town) South Wales, Cumb.
(State or country)

14 Informant Hospital Record
(Address)

15 Filed APR 8 1927 C. HAMPTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to April 16, 1927, that I last saw h/M alive on April 16, 1927, and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of April 13 '27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. C. Hampton Jones, M. D.

, 19 (Address) 1100 W. Mt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Apl 19 1927

UNDERTAKER John F. Leary

ADDRESS 715 Leydon

Spec.—1-10-21—M&T—1500 Bks.

E 21310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9-1-00 V

E 21310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 East Cross ST. 24-33 (WARD)

2-FULL NAME Franklin A. Shrick

(a) RESIDENCE NO. 303 East Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Shrick

6 DATE OF BIRTH (month, day, and year) July 26 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	65	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caldrer

(b) General nature of industry, business, or establishment in which employed (or employer) Can making

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER William Shrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna M Jeffers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah E. Shrick

(Address) 303 East Cross

15 Filed ..... 19 ..... Registrar

R 18 1927 C. HAMILTON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1927

17 I HEREBY CERTIFY, That I attended deceased from November, 1925, to April 15, 1927, that I last saw him alive on April 14, 1927, and that death occurred, on the date stated above, at 10: P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. D. Buxton, M. D.

4/16, 1927 (Address) 301 East Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Cem. Rock Hall Md	Apr 19 1927
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21311

38 E 21311

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md 26-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Goepert

(a) RESIDENCE NO. 262 S. Bonsdale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Goepert

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 31

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Balto City Hosps

(Address) Balto Md

15 Filed ....., 19.... C. HAMPSON JONES, M. D.

APR 16 1927 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-27

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1926, to 4-15, 1927, that I last saw him alive on 4-15, 1927, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH was as follows:

Cerebral Paralysis of Insane

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Septic Infection

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Findings

(Signed) Henry Feldmann, M. D.

4/16/27 Address 1 Boltimore City Hosps

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 19 1927

20 UNDERTAKER Great Eastern ADDRESS 1906 Eastern Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Porter

100-001

CERTIFICATE OF DEATH

E 21312 — REGISTERED No. E 21312

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 Schenley Road St. 27-55 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Caroline Litsinger

(a) RESIDENCE NO. 212 Schenley Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rev. Wm. D. Litsinger

6 DATE OF BIRTH (month, day, and year): Nov 26. 1850

7 AGE — Years: 76 Months: 4 Days: 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): a a Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Wm. Hawkins

11 BIRTHPLACE OF FATHER (City or town): a a Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Leah Lee

13 BIRTHPLACE OF MOTHER (city or town): a a Co

(State or country): Md

14 Informant: Rev. W. D. Litsinger

(Address): 1503 Druid Royal Ave

15 Filed APR 18 1927 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927 to Apr. 16, 1927

that I last saw her alive on Apr. 16, 1927

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis Colitis

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

4/17 1927 (Address) 422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Apr 18 1927

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1900 Eutaw Place

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Bryan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21313

E 21313

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables - ST., 13-52 WARD) 4th Cedar Ave

2-FULL NAME Miss Mary V. Bryan.

(a) RESIDENCE NO. Home for Incurables 4th ST., Cedar Ave WARD Balto- Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard V Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine V Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Home for Incurables (Address)

15 Filed 1927 19 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr- 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 15 19 22 to April 16 19 27

that I last saw her alive on April 16 19 27

and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs — mos — ds.

CONTRIBUTORY (Secondary) Cardiac decompensation (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W. W. Mayo, M. D.

4/16 1927 (Address) 4 Latrobe Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount DATE OF BURIAL April 18 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21314

CERTIFICATE OF DEATH.

11-002

E 21314

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Park ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie H. Terrier

(a) RESIDENCE No. 1615 Park ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews Co Va

PARENTS

10 NAME OF FATHER John E. Terrier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mathews Co Va

12 MAIDEN NAME OF MOTHER Margaret Armistead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records, Baptist Home of MD (Address) 1615 Park ave

15 Filed PR 18 1927 Reg't

THOMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 16. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to April 16, 1927, that I last saw h[illegible] alive on April 15, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) Thompson Jones, M. D.

19 (Address) 2224 N North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Apl 18 1927

UNDERTAKER: John O. Mitchell — ADDRESS: 1900 Eutaw Pl

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21315

CERTIFICATE OF DEATH.

18-26 100-001

E 21315

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 N. Carrollton Ave ST. 18 WARD)

2-FULL NAME Solomon H. Freburger

(a) RESIDENCE No. 539 N. Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Freburger

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Freburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliz. MacDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Herbert H. Freburger

(Address) 539 N. Carrollton Ave

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1927, to Apr. 17, 1927, that I last saw him alive on Apr 16, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Arteriosclerosis Chr.

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Coronary Embolism Suddenly (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? M. E.

(Signed) F. F. Okuda M. D.

, 19 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL April 19 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1905 Eutaw Pl

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21316

CERTIFICATE OF DEATH.

E 21316

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 E. Heath St. 43-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Blair

(a) RESIDENCE NO. 37 E. Heath St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 31, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Blair

11 BIRTHPLACE OF FATHER (city or town): St. Mary's Co.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Murray

13 BIRTHPLACE OF MOTHER (city or town): Charles Co.

(State or country): Md.

14 Informant: Wm Blair

(Address) 37 E. Heath St.

15 Filed ..... 19 C. HARRISON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Apr 15-27

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1927, to Apr 15, 19 27

that I last saw h[illegible] alive on Apr 15, 19 27

and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. L. Lutkenhaus M. D.

4/17/27 (Address) 1111 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: April 18 1927

20 UNDERTAKER: Margaret E. Flynn ADDRESS 1411 Light St.

APR 15 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-203

E 21317

CERTIFICATE OF DEATH.

E 21317
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hildam Heneka.

(a) RESIDENCE NO. 2725 Eastern Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 15 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Heneka

6 DATE OF BIRTH (month, day, and year): Oct 29/1863

7 AGE — Years: 63 Months: 5 Days: 15 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Reliable Furniture Co

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Albert Heneka

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):

(State or country):

14 Informant: Lena Heneka

(Address) 2725 Eastern ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.

Multiple Fracture

(duration) ..... yrs. ..... mos. 10 da

CONTRIBUTORY (Secondary): Shock

(duration) ..... yrs. ..... mos. 10 ds.

(Signed) P C Rodes M. D.

(Coroner)

Apr 14 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial 4/18/1927

20 UNDERTAKER: Jos. Weber & Son ADDRESS 2503 Edmondson

Very Important: See that every question is answered.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

95 ✓

E 21318

CERTIFICATE OF DEATH.

E 21318

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute to Johns Hopkins Hospital St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley E. Brenemon

(a) RESIDENCE NO. 64 th & Phila., Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) March 26/1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Elmer Breneman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Veronia Bosley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harvey Ryckman (Stepfather)

(Address) 64th & Phila. Rd.

15 Filed APR 18 1927 C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Shock-hemorrhage from Mouth and Nose.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Possible degereration of blood vessels (Genitally deficient) (Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

4/18/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial Apr 18 1927

20 UNDERTAKER Wilbur Cook ADDRESS 502 E North Ave

Dec.—1-12-23—M&T—500 Blks.

Dr. Zimmerman 2858 Harford Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21319

CERTIFICATE OF DEATH.

100 E 21319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2011 Robb ST. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Donnelly

(a) RESIDENCE NO. 2011 Robb ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about

7 AGE: Years 75; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Sadie R. Bollinger

(Address) 2858 Harford Road

15 Filed APR 18 1927 Per C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1926, to April 16, 1927, that I last saw h[illegible] alive on April 16, 1927 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. D. Zimmerman M. D.

4/15/27, 19 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: New Cathedral DATE OF BURIAL: Apr 18, 27

20 UNDERTAKER: William Bod ADDRESS: 502 E Nat Ave

ec.—1-12-23—M&T—500 Bks.

Margaret Blucher

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21320 (1)

REGISTERED NO. E 21320

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Margaret Blucher

(a) RESIDENCE NO. 422 S. Payson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): infant

6a If married, widowed, or divorced HUSBAND of or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year) Nov 13 1926

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant pt

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Charles Blucher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elvina Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mr Charles W. Blucher

(Address) 422 S. Payson st

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11 1927 to April 15 1927

that I last saw her alive on April 15 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Edema, Abstrophy of cerebral cortex (duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Elizabeth Sherman M. D.

, 19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Nov 8 1927

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2173 Pa

pec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21321

CERTIFICATE OF DEATH.

E 21321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 77-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophia Kilbourne

(a) RESIDENCE NO. 613 Plymouth Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: A. Carroll Kilbourne

6b DATE OF BIRTH (month, day, and year): Aug 9. 1890

7 AGE — Years: 36 — Months: 8 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas. Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Laura Ebaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): O. F. Slaught 622 Plymouth Rd

15 Filed APR 18 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to April 16, 1927, that I last saw her alive on April 15, 1927, and that death occurred, on the date stated above, at 12.35 a m.

The CAUSE OF DEATH* was as follows:

Embolism

(duration) yrs. mos 15 min ds.

CONTRIBUTORY, (Secondary): Childbirth

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

4/16, 1927 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Apr 19 1927

20 UNDERTAKER: Jos Jacobs & Son ADDRESS: 2175 Pac

Cor.—12-9-25—A Co.—200 Bks.

21322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 21322

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 S. Bond St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Depilipo

(a) RESIDENCE NO. 211 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Depilipo

6 DATE OF BIRTH (month, day, and year) Sept 3 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Nicholas Depilipo

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Liberia Masoni

(Address) 211 S Bond St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocarditis following Lobar Pneumonia 3 wks ago

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilation of heart

(duration) yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

4 17 1927 (Address) 7004 Chancellor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 1927

20 UNDERTAKER Randell Duffield ADDRESS 5 E Lanvale St

very important. See instructions on back of

R 8-1927 C HAMPTON JONES, M.D.

Spec.—12-9-25—A Co.—200 Bks.

Thompson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21323

CERTIFICATE OF DEATH.

90 E 21323

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 5-8 Ward)

BALTIMORE CITY HOSPITALS

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Thompson

(a) RESIDENCE NO. 416 Somerset St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Seth Palmer.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOSPITALS

(Address) [illegible] Records

15 Filed ... 19... Registrar

R 18 1927 Per C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1927

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to April 15, 1927, that I last saw her alive on April 15, 1927 and that death occurred, on the date stated above, at 12:00 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

acute.

Coronary

(duration) ...yrs. 2 mos. 0 ds.

CONTRIBUTORY

(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? general appearance

(Signed) C. Hampson Jones, M. D.

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery Date of Burial April 19, 27

20 UNDERTAKER: Edward Bryan ADDRESS 1651 Orleans St

Cor. 10-3-27-A-o—200 Blks.

E 21324 HEALTH DEPARTMENT—CITY OF BALTIMORE

51 E 21324

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Othello Saunders Grinage

(a) RESIDENCE NO. 912 Rutland Ave St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	singke

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Everett Grinage

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Florence Saunders

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Florence Saunders
(Address) 912 Rutland ave

Filed APR 18 1927 C. HAMILTON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15-27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial failure probably Rheumatic in origin

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) H. L. Kolb M. D.
(Coroner)

4/18/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery Date of Burial april 19 1927

20 UNDERTAKER Edward Bryan ADDRESS 1691 orleans st

pec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21325 — 74001 — V 21325

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilson

(a) RESIDENCE NO. 314 Calhoun Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) Sept 3-1861

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	13	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Service

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Henry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) British West Indies

12 MAIDEN NAME OF MOTHER — Moogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) British West Indies

14 Informant Hospital Records (Address)

15 Filed APR 18 1927 T. HAWKINS JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1926, to April 16, 1927, that I last saw h[e] alive on April 16, 1927, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(recurring attacks)

(duration) yrs. 4½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical findings at autopsy

(Signed) W. W. Bruton M. D.

4-16, 1927 (Address) Asst Surgeon U.S.P.H.S. U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Apr 19 1927

UNDERTAKER E. LeRoy Stiffler

ADDRESS 1252 North ave

Spec.—12-9-25—A Co.—200 Bks.

E 21326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 21326

1-PLACE OF DEATH

City of BALTIMORE: (No. Pimlico Rd. north of Ridgely Ave. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura R. Hodges

(a) RESIDENCE NO. Pimlico Rd. N. of Ridgely Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Henry Hodges

6 DATE OF BIRTH (month, day, and year): Jan. 3 - 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	76	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: James R. Burgess

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma McKim

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: Mrs. Carrie Regan

(Address): Pimlico Rd.

15 Filed: APR 18 1927 Registrar: C. HAYDON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1926 to April 17 1927, that I last saw her alive on April 17 1927, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis Senility

(duration) yrs. mos. 3 ds.

18 Where was disease contracted: 1604 N. Broadway

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis! Clinical

(Signed) C. H. Nunt M. D.

4/19, 1927 (Address) Manhattan Apts K St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Apr. 19 1927

20 UNDERTAKER: Mrs Albert E. Fuller ADDRESS: 4806 Harford ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21327

CERTIFICATE OF DEATH.

E 21327 1 PLACE OF DEATH

Registered No. 001 E 21327

City of BALTIMORE: (No. 652 W. Barre St. 27-30 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mason Hyndman

(a) Residence No. 652 W. Barre St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 45 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Hardmon

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Amelia Hooper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant). Hattie Hardmon

(Address). 652 W. Barre St.

Filed APR 18 1927, 19 HAMILTON JONES, M. D. Registrar.

By [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-14-27

17- I HEREBY CERTIFY, That I attended deceased from 4-14-27, 19 27, to 4-14-27, 19 27.

That I last saw h alive on 4-14-27, 19 at 12:00 AM m.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) 652 W Barre St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. April 18 1927

20-UNDERTAKER. Lamb Eastman

ADDRESS. 916 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21328

CERTIFICATE OF DEATH.

E 21328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 Wilson alley Ward)

2-FULL NAME Amelia Stewart Wallace

(a) RESIDENCE NO. 1215 Wilson alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Wallace

6 DATE OF BIRTH (month, day, and year): about 1857

7 AGE: Years 71 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER Abraham Cook.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER Emily Mobley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Thos. F. Wallace

(Address): 1215 Wilson alley

Filed APR 18 1924 G. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) .....yrs. .....mos. .....ds.

(Signed) G. H. Jones M. D.

(Coroner)

April 18, 1924 (Address) 210 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Date of Burial April 19 1924

UNDERTAKER: Daniel Easter & Son ADDRESS 916

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21329

CERTIFICATE OF DEATH.

129 E 21329

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3935 Greenmount ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lassell Sibley

(a) RESIDENCE NO. 3935 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Catherine Sibley

6 DATE OF BIRTH (month, day, and year) Dec 21, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) salesman

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va. (State or country)

PARENTS

10 NAME OF FATHER Franklin Alexander Sibley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret C. Dozier

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Catherine Sibley (Address) 3935 Greenmount ave

15 Filed APR 18 1927 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-22, 1926, to 4-16-, 1927.

that I last saw him alive on 4-12, 1927

and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Chronic Myo- & Endo-carditis

Chronic nephritis

Hemiplegia (duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) few minutes ~~yrs. mos. ds.~~

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) 2802 Harford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto cemetery — DATE OF BURIAL April 19 1927

20 UNDERTAKER Wm Rouston — ADDRESS 2238 N Wolfe

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21330

REGISTERED No. C E 21330

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 N. Bond ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Rosenthal

(Residence in Baltimore: No. 1008 N Bond St ST. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 12 (Month) (Day), 1856 (Year)

7 AGE: 71 yrs. 10 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Rosenthal

(Address) 1008 N Bond St

15.

Filed APR 16 1927, 191 H. WILSON JONES, M. D. REGISTRAR

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 15 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1926 to April 14 1927.

that I saw h in alive on April 14, 1927.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Myocarditis - Asthma

(Duration) 1 yrs. 1 mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) William H. Schwartz M. D.

April 16, 1927 (Address) 1200 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Gardens DATE OF BURIAL: 4/19, 1927

20 UNDERTAKER: Upshur Coffman ADDRESS: 1796 Eager

It is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21331

E 21331

CERTIFICATE OF DEATH

15-2278

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1327 N.Fulton Avenue St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Gertrude Stehl

(a) RESIDENCE NO. 1327 N.Fulton Avenue St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 10 mos. 0 ds. How long in U. S. If of foreign birth 24 yrs 10 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June-14-1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	24	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Stehl

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie L.Buckingham

13 BIRTHPLACE OF MOTHER (city or town) Woodensburg

(State or country) Maryland

14 Informant Mrs.William Stehl (mother)

(Address) 1327 N.Fulton Avenue

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

APR 18 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1927, to April 14, 1927, that I last saw her alive on April 14, 1927, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Wende, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial April-18-27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Very Important. See instructions on back of this certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21332

100-001

CERTIFICATE OF DEATH

E 21332

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bussman

(a) RESIDENCE NO. 515 Lancaster St. 3 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 3 mos. / ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Bussman

6 DATE OF BIRTH (month, day, and year) Jan. 13th 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer D40

(b) General nature of industry, business, or establishment in which employed (or employer) Metal Package

(c) Name of employer

9 BIRTHPLACE (city or town) Corp.

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Earl Bussman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Jennie Bussman

(Address) 515 Lancaster St.

15 Filed APR 18 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/6 19 27 to 4/14 19 27

that I last saw h[illegible] alive on 4/14 19 27

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical Signs

(Signed) E. B. Miller M. D.

19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial Apr 18 1927

26 UNDERTAKER Lilly & Zeiler ADDRESS 408 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 21333

REGISTERED NO.

E 21333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Harlem ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Burgess

(a) RESIDENCE NO. 1703 Harlem ST., ... WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER John Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Susanna F Burgess

(Address) 1703 Harlem Ave H.D.

15 Filed APR 18 1927 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 13, 1927.

That I last saw her alive on April 13, 1927.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senile Condition

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cancer of Breast

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of — — —

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) John Moran, M. D.

, 19 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 18 1927

20 UNDERTAKER George J Smith ADDRESS 153 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21334 E 21334

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3806 Woodbine Ave ST. 56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Gustine Mason

(a) RESIDENCE NO. 3806 Woodbine Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Mason

6 DATE OF BIRTH (month, day, and year) Feb 18 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Matthews Co (State or country) Va

PARENTS

10 NAME OF FATHER Miles Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Shuck

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md

14 Informant L. L. Davis

(Address) 3806 Woodbine Ave

APR 18 1927 HARRY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-14 1927, to 4-16 1927, that I last saw her alive on 4-16 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris.

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Merrill Sorrell M. D.

, 19 (Address) 3205 Liberty Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: April 19 1927

20 UNDERTAKER: Putnam & Sons — ADDRESS: 1723 W Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

(St. Paul) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21335

CERTIFICATE OF DEATH.

45

E 21335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 234 Collins Ave ST., West WARD 71

2-FULL NAME James A. Frothingham

(a) RESIDENCE NO. 234 Collins Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine W. Frothingham

6 DATE OF BIRTH (month, day, and year): Aug 1st 1864

7 AGE: Years 62; Months 8; Days 13; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R. 031

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Matthew Frothingham

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Priscilla Merson

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

14 Informant (Address): Catherine W. Frothingham 234 Collins Ave

15 Filed ....., 19..... Per ..... Registrar

C. HAMPTON JONES, M. D.

APR 18 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1927, to Apr 15 1927.

that I last saw h— alive on Apr 15 1927

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia of Pulmonary

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/7/27

Was there an autopsy?

What test confirmed diagnosis? Physical & Operation

(Signed) W. A Kuell, M. D.

4/17, 1927 (Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	April 18th 1927

UNDERTAKER	ADDRESS
F. B. Hufford	850 N. Eutaw

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21336 — 101-001 — E 21336

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 745 Dover St. 21-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Holt Smith

(a) RESIDENCE NO. 745 Dover St. Ward Phila

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 10 mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May - 22 - 1926

7 AGE — Years: — Months: 10 Days: 27 (26) IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant - nil

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Philadelphia

(State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: George Smith

11 BIRTHPLACE OF FATHER (City or town): Stafford

(State or country): Canada

12 MAIDEN NAME OF MOTHER: Willie Branch

13 BIRTHPLACE OF MOTHER (city or town): Newton Nans

(State or country): Virginia

14 Informant: Willie Smith

(Address): 745 Dover St

15 Filed: 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/18 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/13, 1927, to 4/17, 1927, that I last saw him alive on 4/17, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David Franklin, M. D.

4/18, 1927 (Address) 122 W 4th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: April 20 1927

20 UNDERTAKER: J. H. Brown's Son — ADDRESS: Fort Mary

Very Important: See instructions on reverse side.

APR 18 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21337

CERTIFICATE OF DEATH

38

E 21337

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 728 S. Hanover St., 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hardman

(a) RESIDENCE NO. 728 S Hanover St. Ward 22

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Hardman

6 DATE OF BIRTH (month, day, and year): March 1860

7 AGE: Years 67 Months Days 24. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob Brown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Irene Boardley

(Address) 728 S Hanover St.

15 Filed APR 19 1927 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3/14 19 27 to 4/15 19 27

that I last saw h alive on 4/15 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Arthritis Sclerosis Probably Deliri

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/16 19 27 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

Date of Burial: April 19 19 27

20 UNDERTAKER: D. H. Brown & Son

ADDRESS: Pennsylvania Ave

Very Important. Use typewriter or pen and ink. Be careful to answer all questions.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21338

CERTIFICATE OF DEATH.

90 ✓

E 21338

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 26-37 REGISTERED NO.

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Kattenborn

(a) RESIDENCE NO. 410 South 5th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Fritz Kattenborn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Smoot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address)

15 Filed, 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1926, to April 16, 1927, that I last saw him alive on April 16, 1927, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis & ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Stoops Leutt, M. D.

April 17 1927 (Address)

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Grove Date of Burial April 19 1927

20 UNDERTAKER ADDRESS

Ulm - Mrs. A. S. Pimlf 2512 Wilkens Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21339

CERTIFICATE OF DEATH.

31 E 21339

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3217 Brighton ST. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Connelly.

(a) RESIDENCE NO. 3217 Brighton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 17-1909

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
17	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Terence J. Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Caroline Seaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mr Albert B Williams

(Address) 3217 Brighton St.

15 Filed R 18 1927 C. HARRISON JONES, M. D. Registrar

Per KM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1926 to April 16, 1927.

that I last saw him alive on April 16, 1927.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. Orrill M. D.

4/17, 1927 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: 4/19 1927

20 UNDERTAKER: John F. Cowan & Son

ADDRESS: 90 Holliday St.

Per F. F. Cowan

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21340

45 E 21340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 w Fayette St., 14-27 Ward)

2-FULL NAME William P. Clark.

(a) RESIDENCE NO. 1602 w Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 16 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine G. McPhillips Clark

6 DATE OF BIRTH (month, day, and year): June 30 " 1865.

7 AGE: Years 61 | Months 9 | Days 16 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Sales.

(b) General nature of industry, business, or establishment in which employed (or employer): Ga Electric Co

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: James F. Clark.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mulvaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland.

14 Informant: Mrs Catherine G. Clark.

(Address): 1602 w Fayette St.

Filed APR 18 1927 Per

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 16 " 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1926, to April 16, 1927, that I last saw ~~him~~ alive on April 15, 1927, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. Oneill, M. D.

4/17, 1927 (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial 4/19 1927

UNDERTAKER: Powar & Son — ADDRESS: Gorsuch

G. F. Cowan — Gorsuch

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21341

CERTIFICATE OF DEATH.

E 21341

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N Arlington ~~St.~~ Ave. WARD 16-26)

2-FULL NAME John E Ward.

(a) RESIDENCE NO. 426 N. Arlington ST. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 0 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Words (Fahey)

6 DATE OF BIRTH (month, day, and year) Apr 12th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~—~~ None

(b) General nature of industry, business, or establishment in which employed (or employer) City.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Ward.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Catherine Ward (Address) 426 N Arlington Ave.

15 Filed APR 8 1927, 19 C. HAMILTON JONES, M. D. Per ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 1. 1927, to April 16 1927, that I last saw him alive on April 16/27 19 and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A D Driscoll, M. D.

, 19 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 4/20/1927

20 UNDERTAKER Edward F. Cowan & Son Per F. J. Cowan

ADDRESS 901 Holbrook St

Spec—12-23-21—E.B.R.S.—400 Eks.

Aged Home

Towson 3224

21342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21342

CERTIFICATE OF DEATH.

Registered No. 27539

1-PLACE OF DEATH

City of BALTIMORE: (No. Kirkleigh) (St. Roland ave) (Ward)

(If death occurred in hospital or institution give its NAME instead of street and number.)

2-FULL NAME Eliza Jane O'Neill

(a) Residence No. Kirkleigh (St. Roland ave) Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 26 - 1843

7-AGE, 83 yrs. 3 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER John O'Neill

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Margaret McGlynn

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Ireland

14- (Informant) Margaret Burke

(Address) 2765 Tivoly Ave

15- Filed 8 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16 1927

17- I HEREBY CERTIFY, That I attended deceased from July 16 1926 to April 16 1927 that I last saw h.. alive on April 16 1927 and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

" Senile Regurgitation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Claude M. D.

April 16 1927 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. April 19 1927

20-UNDERTAKER. Chas S. Braun & Son

ADDRESS 1810 W. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

E 21343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 21343

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 10-14 WARD)

2-FULL NAME Mrs Catherine Alive Burke

(a) RESIDENCE NO. 715 E Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Burke

6 DATE OF BIRTH (month, day, and year): Feb 17 - 1894

7 AGE: Years 33 Months 2 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Samuel McComb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie McDermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John E. Burke (Address) 715 E. Chase st

15 Filed 8 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/17 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 27 to 4/17, 19 27 that I last saw her alive on 4/17/27, 19 27, and that death occurred, on the date stated above, at 11 51 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL 4/21, 19 27

20 UNDERTAKER: Chas F. Mause Son ADDRESS 118 Mont Royal Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21344

90 E 21344

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 3114 Abell Ave. St. 17-50 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Crane Kidd.

(a) RESIDENCE NO. 3114 Abell Ave. St. _____ Ward _____

(Usual place of abode) 50

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Kidd

6 DATE OF BIRTH (month, day, and year) January 10th. 1848

7 AGE	Years	Months	Days
	79	3	7

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Ireland

PARENTS

10 NAME OF FATHER Charles Crane

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Nolan

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 Informant Miss Kidd

(Address) 3114 Abell Ave.

15 Filed _____ 19 _____ _____ Registrar

1927 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 17th. 1927

17 I HEREBY CERTIFY, That I attended deceased from June – 19 26 to April 17. 19 27

that I last saw him alive on April 16. 19 27

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) – yrs. 10 mos. – ds.

CONTRIBUTORY (Secondary) _____

(duration) – yrs. – mos. – ds.

18 Where was disease contracted _____

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) [illegible] M. D.

4/8 19 27 (Address) 220 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery. Date of Burial 4/20 27

20 UNDERTAKER Chas. P. Crane & Son ADDRESS 118 W. Mt. Royal Ave.

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21345 E 21345

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 St. Paul ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Appleton Wilson

(a) RESIDENCE. NO. 1013 St. Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary W. Wilson

6 DATE OF BIRTH (month, day, and year) Oct 9 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	8/10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Architect

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Franklin Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Virginia Appleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland Maine

14 Informant Rupert Goodenow Jr. (Address) # 4 Bolton Square Baltimore

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1927, to April 17th, 1927, that I last saw h[e] alive on April 17th, 1927, and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Myocarditis

Angina Pectoris

(duration) yrs. 17 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C B Gambrall, M. D.

19 (Address) 2 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL April 20 1927

20 UNDERTAKER Jno B Spence ADDRESS 1325 N Carlton St

8 1927

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100,001

E 21346

21346

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Lewis

(a) RESIDENCE NO. 1322 Penna Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S. if of foreign birth? —yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Lewis -

6 DATE OF BIRTH (month, day, and year) Dec. 25. 1869

7 AGE 57	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	57	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - Odd

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Buddy Lewis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) S. C.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Joe Lewis

(Address)

C. HAMPSON JONES, M. D.

Registrar

1927

1258 THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 1. 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1927, to April 1, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 9:50 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure -

Acute Cardiac Dilatation

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Broncho-Pneumonia -

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John F. Graham, M. D.

, 19 (Address) Colonial Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER Commissioner Health.

ADDRESS

UNIVERSITY OF MARYLAND

Pat. Wm. E. Woodall

Very Important. See Instructions on back

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21347

E 21347

CERTIFICATE OF DEATH.

185

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 4-27 Ward)

2-FULL NAME Julia Boston

(a) RESIDENCE NO. 413 N. Pennsylvania St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

18 1927 Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

Per _____

1269

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927 to April 10, 1927

that I last saw her alive on April 10, 1927

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Supracondylar Fracture of femurs - (over)

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Eugene [illegible], M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

Date of Burial: 19

20 UNDERTAKER: Commissioner Health

ADDRESS

Per. Wm. H. Woodall

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21348

101-001

E 21348

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hosp 628 St., East Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Baker

(a) RESIDENCE NO. 122 East St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

1260

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1927, to April 13, 1927, that I last saw him alive on April 13, 1927, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows: Cardiac Decompensation

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John Camper M. D.

, 19 (Address) Providence Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

Very Important. See instructions on back

UNIVERSITY OF MARYLAND
Commissioner Health.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21349

E 21349

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St., 17-24 Ward)

2-FULL NAME Marion Washington

(a) RESIDENCE NO. 562 Grunwellow St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Washington

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address) Records

Filed 8 1927 C. HAMPSON JONES, M. D.

Per RCB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to April 15, 1927, that I last saw h.e alive on April 14, 1927, and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Myocardial Hypertrophy &

Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY Myocardial Failure

(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gunsul & Laboratory

(Signed) C. Hampson Jones, M. D.

April 19 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Brewer Hill Cemetery Annapolis April 19 1927

20 UNDERTAKER ADDRESS

Joseph D. Warwick Annapolis Md

ec.—1-12-23—M&T—500 Bks.

E 21350

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21350

CERTIFICATE OF DEATH.

161-001

8-17

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 E Preston ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Delprete Jr.

(a) RESIDENCE NO. 1636 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

6 If married, widowed, or divorced HUSBAND of (or) WIFE of child

7 DATE OF BIRTH (month, day, and year) 4/18-27

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Vincent Delprete

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Emma Desanga

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Delprete (Address) 1636 E Preston St

15 FILED 8 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/18, 1927, to 4/18, 1927, that I last saw him alive on 4/18, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity 6 mos white

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Carter M. D.

4/18, 1927 (Address) 2105 N Belte St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL April 18 1927

20 UNDERTAKER Edmund W. Conklin — ADDRESS 124 E. Fayette St.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21351

100-001

E 21351

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 634 S. 15th St. St., 26-37 Ward)

2-FULL NAME Margaret A. Schmidt.

(a) RESIDENCE NO. 634 S. 15th St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22-1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		2	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Schmidt.

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Coker

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant (Address) John Schmidt. 634 S. 15th St.

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-1927

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 17, 1927, that I last saw h.. alive on April 17, 1927, and that death occurred, on the date stated above, at 11.50 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial - Pneumonia

(duration) ___ yrs. ___ mos. 2 ds.

CONTRIBUTORY (Secondary)

Malnutrition (duration) since birth yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Davidson, M. D.

, 19 (Address) 3035 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial April 19 1927

20 UNDERTAKER Lilly & Zuiler ADDRESS 403 S. Wolfe St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21352

E 21352

CERTIFICATE OF DEATH.

74-007

93-21

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1815 Clarkson St. Ward

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Dailey.

(a) RESIDENCE NO. 1815 Clarkson St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

5a If married, widowed or divorced HUSBAND of (WIFE of) Catherine Conway.

6 DATE OF BIRTH (month, day, and year) June 19, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor.

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Martin Dailey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Kelley.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Catherine Dailey. (wife)

(Address) 1815 Clarkson St.

Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) 9 yrs. mos. X ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

4/18 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial Apr. 18 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21353

CERTIFICATE OF DEATH

90 E 21353

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 413 Warren Ave. St., 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Dougherty

(a) RESIDENCE NO. 413 Warren Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Patrick Dougherty

6 DATE OF BIRTH (month, day, and year): July 5. 1856

7 AGE: Years 70 Months 9 Days 10 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Thos. McHugh

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Farrel

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Thos. F. McHugh

(Address) 413 Warren ave.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from March, 19 25, to April 15, 19 27

that I last saw h[illegible] alive on April 15, 19 27

and that death occurred, on the data stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Myocardial Degeneration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Acute Cardiac Dilatation

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stanton McLeary, M. D.

19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial: April 19 1927

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light

Very Important. See instructions on back of certificate.

APR 19 1927

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21354 E 21354

CERTIFICATE OF DEATH.

21354

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2621 Hafer ST. (Or) WARD

2-FULL NAME Herman Herdzelis

(a) RESIDENCE NO. 2621 Hafer ST. 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Johanna Herdzelis

6 DATE OF BIRTH (month, day, and year): Nov 30th 1843

7 AGE: Years (83) Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Herdzelis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Smith

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Louis L. Herdzelis (Address) 2621 Hafer St

15 Filed 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): before 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1927, to April 17th, 1927, that I last saw him alive on April 17 1927, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2651 Hafer St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Chemical

(Signed) August Stolze M. D.

4-12, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL April 20 1927

20 UNDERTAKER: F. B. Kefauver ADDRESS 855 N. Bond St

Cor.—12-9-25—A Co.—200 Bks.

(Szymaniak)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21355

CERTIFICATE OF DEATH.

X 185

E 21355

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Szymaniak

(a) RESIDENCE NO. North Point Rd. & Wise Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Szymaniak

6 DATE OF BIRTH (month, day, and year) Jan 19-1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	3½	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0 6

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mary Szymaniak

(Address) North Point Rd & Wise ave

15 Date 8 1927 C. HAMPSON JONES, M. D.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage & Extreme Surgical Shock due to fall on Circular Saw, Lacerating Rt Scalp & Fracture of R. Humerus Compound

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident

(duration) yrs. mos. ds.

(Signed) James M. Fenton, M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Pt & Wise ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Apr 20 1927 Date of Burial

20 UNDERTAKER John M Weber ADDRESS 1803 Back St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21356

CERTIFICATE OF DEATH.

101-001

E 21356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 W. Mulberry ST. 4-16 WARD)

2-FULL NAME Pauline Geneva Russell

(a) RESIDENCE NO. 745 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER John Russell

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Martha E. Sullivan

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant (Address) Mrs Lucetta 745 W. Mulberry St

15 Filed 4-19-1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 16, 1927, that I last saw h[illegible] alive on April 16, 1927, and that death occurred, on the date stated above, at 4:25 [illegible] m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (a) Anemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Hunter H. Hooker, M. D.

19 (Address) 714 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4-19 1927

20 UNDERTAKER John H. Soaden

ADDRESS 1027 Hanover

Dec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21357

CERTIFICATE OF DEATH.

3 1 E 21357

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mankie Stein

(a) RESIDENCE NO. 2102 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: white

5 [redacted]gle, Married, Widowed, or Divorced, (write the word): M.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John Stein

7 DATE OF BIRTH (month, day, and year): Jan 22. 1871

8 AGE: 56 Years 55 Months 3 Days 26 If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: not given (Unknown)

11 BIRTHPLACE OF FATHER (city or town) (State or country): " " Md.

12 MAIDEN NAME OF MOTHER: " " Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " " Md.

14 Informant: John Stein (Address) 2102 Bank St

15 Filed [illegible] 1927 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-22 , 1927 , to 4-18 , 1927 , that I last saw her alive on 4-18 , 1927 , and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Pyelonephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/18/27

Was there an autopsy? lab. tests.

What test confirmed diagnosis?

(Signed) W. P. L. McBride, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 19 1927

20 UNDERTAKER: Lee Cook — ADDRESS: 202 E Hoffman

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21358

CERTIFICATE OF DEATH

E 21358

REGISTERED NO. 24001 E 21358

1 PLACE OF DEATH

City of BALTIMORE: (No. 521 Wellesley St. 20-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kelley Sr.

(a) RESIDENCE NO. 521 Wellesley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married,~~ Widowed, or ~~Divorced,~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Kelley

6 DATE OF BIRTH (month, day, and year): March 20, 1864

7 AGE: Years 63 Months 0 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired, M.D.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: None

9 BIRTHPLACE (city or town): Mass.

(State or country)

PARENTS

10 NAME OF FATHER: John Kelley

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Edward Kelley

(Address) 521 Wellesley St.

15 Filed APR 19 1927, 19 . C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 19 7, to 4/18, 19 27, that I last saw him alive on 4/17/27, 19 , and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis with hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Duncan Pollock, M. D.

, 19 (Address) 3306 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem't Date of Burial Apr 20 1927

20 UNDERTAKER: William Cook ADDRESS 502 E Monument

Very important. See instructions on reverse side.

E 21359

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21359

10-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 26-36 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Boone

(a) RESIDENCE NO. St Helena ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1923

7 AGE — Years: 4 Months: 0 Days: 7 5 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown (

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Lottie Ashley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Falker (Step father)

(Address) St. Helena

15 Filed APR 19 1927 E. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to April 17, 1927, that I last saw her alive on April 17, 1927, and that death occurred, on the date stated above, at 10:9 P. m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Cult.

(Signed) Myron G. Tull, M. D.

4/18 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: 4/19 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21360

CERTIFICATE OF DEATH.

E 21360

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 E Fayette ST. 5-8 WARD)

2-FULL NAME Sara Wilenchick (Wilenchuck)

(a) RESIDENCE NO. 1325 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Moses Wilenchick

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no occupation

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Jack Lewis
(Address) 1739 E Baltimore St

15 Filed APR 19 1927 HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-15-1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1917, to April-15-, 1927, that I last saw her alive on April-15-, 1927, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) none
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Herman Seidel, M. D.

4/15 1927 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cem. Rosh Pauk ✝ Rd

DATE OF BURIAL 4/19 1927

20 UNDERTAKER Herman Seidel

ADDRESS Jack Lewis 1709 E Balto ✝

...ec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21361

CERTIFICATE OF DEATH.

129 E 21361

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 930 Aisquith ST. 10-14 WARD)

2-FULL NAME Adilla Monk.

(a) RESIDENCE NO. 930 Aisquith ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Monk

6 DATE OF BIRTH (month, day, and year): Jan 20 1896

7 AGE — Years: 31 — Months: 2 — Days: 18 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Raleigh N. C.

PARENTS

10 NAME OF FATHER: H. J. Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Margret Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Margret Armstrong

(Address): 93 Aisquitte st

15 Filed ... 19 ... Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1927, to April 17, 1927, that I last saw her alive on April 17, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis & Complication Disease

(duration) 2 yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Postive

(Signed) Dr G W Kennard, M. D.

4-17 1927 (Address) 708 Ensor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 4-19 1927

20 UNDERTAKER: Jas. H. Skinner

ADDRESS: 1625 E. Broad St

Cor.—12-9-25—A Co.—200 Bks.

STORES

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21362

E 21362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1703 W. Lafayette St. 16-22 Ward)

2-FULL NAME Blanche Stokes

(a) RESIDENCE NO. 1703 W. Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of Blanche Stokes (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coconut Seller

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Retired

(State or country)

PARENTS

10 NAME OF FATHER Preston Stokes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Lewis

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md

14 Informant Blanche Stokes

(Address) 1703 W. Lafayette Ave

Filed 19 1927 C. HAMILTON JONES, M. D.

For K.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastric enteritis 5 hours,

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fatty degeneration of heart

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Coroner)

April 6 19 27 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 4/8/27

20 UNDERTAKER Samuel T. Busey ADDRESS 3 N. Eden

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21363
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 21363
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 914 E. Preston ST., 9-18 WARD)

2-FULL NAME Mrs. Brigid Campbell

(a) RESIDENCE NO. 914 E. Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. ? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Thomas Campbell

6 DATE OF BIRTH (month, day, and year): Oct. 28, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown Ireland

PARENTS

10 NAME OF FATHER: Hugh Craven

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Ireland

12 MAIDEN NAME OF MOTHER: ? McGinnis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Ireland

14 Informant: Miss Rose Campbell
(Address) 914 E. Preston St.

15 Filed APR 19 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927. to April 17, 1927.
that I last saw her alive on April 17, 1927.
and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Apr 21 1927

20 UNDERTAKER: Rida Weinfeld — ADDRESS: 914 Fremont Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21364

168

CERTIFICATE OF DEATH.

E 21364

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 Greenmount St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Dragesser

(a) RESIDENCE NO. 1012 Greenmount ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Dragesser

6 DATE OF BIRTH (month, day, and year) Oct 1 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer at home

9 BIRTHPLACE (city or town)

(State or country) Baltimore City

PARENTS

10 NAME OF FATHER Owen Dawson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Dunigan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Margaret Hairs

(Address) 1012 Greenmount ave

15 Filed ....., 19..... C. HAMPTON JONES, M. D.

Per ..... Registrar

APR 19 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging

Emer Lab while insane

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Insanity

(duration) yrs. 3 mos. ds.

(Signed) James M. Fenton M. D.

(Coroner)

4/19 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Apr 20 1927

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Greenmount Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21365

CERTIFICATE OF DEATH.

49 E 21365

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kerns

(a) RESIDENCE NO. 1733 E. Oliver St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Kerns

6 DATE OF BIRTH (month, day, and year): April 3 1875

7 AGE: Years 52 | Months - | Days 14 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Transfer Business

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Kerns

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Angelia Kurz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Records

(Address)

Filed APR 9 1927 JOHN C. HAM[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 19 27 to April 17, 19 27, that I last saw h[illegible] alive on April 17, 19 27, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid Gland.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia. Mediastinitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? Yes Date of April 13, 1927

Was there an autopsy? No

What test confirmed diagnosis? Examination of tissue

(Signed) Warfield M. Firor, M. D.

April 17, 1927 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Apr. 20 1927

20 UNDERTAKER: Henry Storck & Son — ADDRESS: 1301 E. Eager St.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21366
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

12-2057

E 21366
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1729 Madison Ave. WARD)

2-FULL NAME Nellie Tucker

(a) RESIDENCE NO. 1729 Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Tucker

6 DATE OF BIRTH (month, day, and year) May 5 1889

7 AGE — Years: 37 — Months: 11 — Days: 13 — If less than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs Louis Linden

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va

PARENTS

10 NAME OF FATHER Winfred Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va
12 MAIDEN NAME OF MOTHER Martha Green
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucille Herbert
(Address) 1643 N. Arms St. Phila Pa

15 Filed ... 19... C. HAMPTON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 18, 1927, that I last saw her alive on April 17, 1927 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Influenza - Pulm. Embolism
(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Diabetes
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical-Personal

(Signed) Wm N. Wright, M. D.
4/18, 1927 (Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn
DATE OF BURIAL: 4-21 1927

20 UNDERTAKER: George I. H. Gibson
ADDRESS: 1733 W. Pratt
Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21367

100-001

E 21367

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 26-40 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth S Gillespie

(a) RESIDENCE NO. 3335 Roosevelt ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: 73. 14 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: John Dickinson

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Caroline Woodall

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant (Address): Balto City Hospitals

15 Filed APR 19 1927 C. HAMPSON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17, 1927

17 I HEREBY CERTIFY, That I attended deceased [from Nov. 19 1926 to April 17 1927

that I last saw h alive on April 16 1927

and that death occurred, on the date stated above, at 3:25 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + autopsy

(Signed) John F. Donnelly M. D.

(Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Apr 19 1927

20 UNDERTAKER: Henry Sandorf Sons Inc — ADDRESS: 1710 Fleet St.

Spec.–7-17-26—A Co.—200 Bks.

E 21368

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 E 21368

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital) 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Dorsey

(a) RESIDENCE NO. 722 N Spring St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. da. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edmond Dorsey

6 DATE OF BIRTH (month, day, and year) July 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER James E. Smith

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Augusta Jefferson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant James E. Smith

(Address) 722 N Spring St

15 Filed APR 19 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1927, to April 16 1927

that I last saw h[illegible] alive on April 16 1927

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 4 mos. da.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Chester Elliott, M. D.

April 19 27 (Address) 5 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Calvary Cem.	Apr. 19 1927
20 UNDERTAKER Mrs. A. C. Elliott	ADDRESS 1723 Eastland Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21369

CERTIFICATE OF DEATH.

E 21369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Harlam Avenue St.) 16-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ruth Hardingham

(a) RESIDENCE. No. 3002 Harlam Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9. 1927

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.
	—	—	7 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John L. Hardingham

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Anna L. Klender

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant John L. Hardingham (Address) 3002 Harlem ave

15 Filed APR 19 1927 19 C. HAMPSON JONES, M. D. Registrar Per R L

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9. 1927. to April 17. 1927. that I last saw h[illegible] alive on April 17. 1927. and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth. (6½ month) and undeveloped organs of Respiratory Heart

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Atelectasis + asphyxia (duration) yrs. mos. 12 hours

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? External inspection

(Signed) Wm. Grant M. D.

. 19 (Address) 3217 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 4/19 19 27

20 UNDERTAKER: Geo. Weber & Son ADDRESS 2503 Edmondson

pec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21370

CERTIFICATE OF DEATH.

10-003

E 21370

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 28-1st WARD)

2-FULL NAME John Edward McCurdy

(a) RESIDENCE NO. 3500 Gwynndale Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 22. 1920

7 AGE: Years 6 | Months 4 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Austin L. McCurdy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Marie Ditzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. Marie McCurdy

(Address): 1901 Orleans St

15 Filed APR 19 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to April 18, 1927, that I last saw him alive on April 18, 1927, and that death occurred, on the date stated above, at 8⁰⁰ P m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult

(Signed) Myron S. Tull, M. D.

4/19, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Apr 19 1927

20 UNDERTAKER: John Ulrich

ADDRESS: 2908 Orleans St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21371

CERTIFICATE OF DEATH.

E 21371

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Friegman

(a) RESIDENCE NO. Chicago, Ill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16, 1904

7 AGE Years 22 Months 8 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Marine

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dumont, Iowa

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Serg. Geo Lestock

(Address) 115 - Gay St

15 Filed APR 19 1927 C. HAMPSON JONES, M. D. Registrar

Per R K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained at the Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Both legs Crushed by being run over by B+O Train at Lanaconing, Md (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidentally fell under train (duration) yrs. mos. ds.

Apr 16 (Signed) Thos B Norton M. D. (Coroner)

17 1927 (Address) Curtis Bay, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF [illegible] Date of Burial Elkridge Md 4/19 1927

20 UNDERTAKER McCook ADDRESS 602 E Nth

Spgc.—1-12-23—M&T—500 Bks.

E 21372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 21372

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25-54 McCulloh ST. 13-54 WARD)

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 25-54 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced (or) WIFE of John Brown

6b DATE OF BIRTH (month, day, and year) 1860

7 AGE: Years 67 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Enoch Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Sarah Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Heaps (Address) 624 N. Eutaw St.

15 Filed 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1927, to 4/16, 1927, that I last saw her alive on 4/16, 1927, and that death occurred, on the date stated above, at 10-P m.

The CAUSE OF DEATH* was as follows:

a. Influenza

b. Pneumonia (duration) 2 mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhart, M. D. (Address) 1 E Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 4/19 1927

UNDERTAKER Enston

ADDRESS 916 Park Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21373

CERTIFICATE OF DEATH

101-001

E 21373

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1719 W Franklin St. W-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Mavis Cobb

(a) RESIDENCE NO. 1719 W Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Blk

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 16/25

7 AGE — Years: 1 Months: 11 Days: 28 2

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Baltimore City

(State or country) Md

PARENTS

10 NAME OF FATHER Jas C Cobb

11 BIRTHPLACE OF FATHER (City or town) St Marys County

(State or country)

12 MAIDEN NAME OF MOTHER Esther Monicue

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant (Address) Jas C Cobb 1719 W Franklin

15 Filed APR 19 1927 H. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 17, 1927, to Apl 18, 1927.

that I last saw him alive on Apl 18, 1927.

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos 2 ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Stuart Tolman, M. D.

, 19 (Address) 1719 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: April 19/27

20 UNDERTAKER: Daniel Easter — ADDRESS: Eager St

Very important. See instructions on back of certificate

Cor.—12-9-25—A Co.—200 Bks.

Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 21374

REGISTERED NO. E 21374

1-PLACE OF DEATH

City of BALTIMORE: (No. 225 Chase St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Johnson

(a) RESIDENCE NO. 225 Chase St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Teakle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mariah Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Jones
(Address) 225 Chase St

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

OCT 19 1927 Per R.F.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Dennison, M. D.
(Coroner)

Oct 19, 1927 (Address) 2808 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial April 19 1927

20 UNDERTAKER Daniel Carbin ADDRESS 516 Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21375

CERTIFICATE OF DEATH.

E 21375

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4106 E. Lombard St. 46-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Esther Estella Colwell

(a) Residence No. 4106 E. Lombard St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of no

6-DATE OF BIRTH (month, day and year) Jan 25 1926

7-AGE. 1 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. no

(b) General nature of Industry, business, or establishment in which employed (or employer). no

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Russell Colwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hagerstown

12-MAIDEN NAME OF MOTHER, Harriet Seifert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Harriet Colwell.

(Address) 4106 E. Lombard

15- Filed APR 19 1927 19 C. HAMPSON JONES, M. D. Registrar.

Per K H

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 18-1927

17- I HEREBY CERTIFY, That I attended deceased from April 2 19 27 to April 18 19 27

that I last saw h.e alive on April 18. 19 27.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) X yrs. X mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) X yrs. X mos. 4 ds.

18-Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? same

(Signed) Jas. L. Duncan M. D

April 18 1927 (Address) Eastern Ave & N.P. Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem. DATE OF BURIAL. April 19. 1927

20-UNDERTAKER. Lilly & Julius ADDRESS 403 S. Wolfe St.

ec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21376 124 E 21376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & alley ST., 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Schever.

(a) RESIDENCE NO. 101 E Brentwood ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): m.

6a If married, widowed, or divorced HUSBAND) of or) WIFE of Frank B. Schever

6 DATE OF BIRTH (month, day, and year) Nov 10-1869

7 AGE 57 Years — 5 Months — 17 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria Germany

PARENTS

10 NAME OF FATHER Adolph Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Langhauser.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry B. Schever (Son)
(Address) 1050 Rochester Place

15 Filed 1927, 19 C. HAMILTON JONES, M. D. Registrar

Past

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/16/27, 192, to 4/17/27, 1927, that I last saw h alive on 4/17/27, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 Mo

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. McCaull, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: April 20 1927

20 UNDERTAKER: D. Lilly and Zeiler ADDRESS: 403 N. Wolfe St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21377

CERTIFICATE OF DEATH.

10-001

E 21377

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2122 Pulaski St. 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence C. Fee

(a) RESIDENCE NO. 2122 Pulaski St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16, 1924.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Herbert M. Fee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lucy J. Hull

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Herbert M. Fee

(Address) 2122 Pulaski St.

15 Filed April 19 1927 C. HAMPSON JONES, M. D.

By RM Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) A. T. Kenney, M. D.
(Coroner)

April 19 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

Date of Burial April 19 1927

20 UNDERTAKER H. M. Routson

ADDRESS 2200 W. North

Spec.—1-12-23—M&T—500 Bks.

E 21378 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 21378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1909 McKean Ave. REGISTERED NO.....

CITY OF BALTIMORE: (NO. 15-H ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Louise Horstman.

(a) RESIDENCE NO. 1909 McKean Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry H. Horstman

6 DATE OF BIRTH (month, day, and year) May 10 - 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
~~70~~	70	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Mertens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Ortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry H. Horstman (Address) 1909 McKean Ave

15 Filed 19 1927 19 Per [illegible] Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 17 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to April 17, 1927 that I last saw h[illegible] alive on April 17, 1927 and that death occurred, on the date stated above, at 1-30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs mos ds.

CONTRIBUTORY (Secondary) acute dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fethat-off, M. D.

, 19 (Address) 1807 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 5-20-27

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1927 North Ave.

Cor.—12-9-25—A Co.—200 Bks.

John R. Miller

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21379

CERTIFICATE OF DEATH.

100-001

E 21379

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 15-21 Ward)

2-FULL NAME John R. Miller

(a) RESIDENCE NO. 1624 N. Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Oct 16, 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER John W. Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto md

12 MAIDEN NAME OF MOTHER Jennie Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto md

14 Informant Jennie Miller

(Address) 1624 N Bruce St

15 Filed C. HAMPSON JONES, M. D.

Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

(Coroner)

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs.,....mos.,....ds. In the State....yrs.,....mos.,....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial April 19 1927

20 UNDERTAKER Thomas G. Kelson ADDRESS 1303 Pressman St.

1327

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21380 E 21380

CERTIFICATE OF DEATH.

REGISTERED NO. 573-51 57

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Green

(a) RESIDENCE NO. 3018 Cedar Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Charles L Green

6 DATE OF BIRTH (month, day, and year) March 9 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lucin Fair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles Green
(Address) 3018 Cedar Ave

15 [illegible] 1927 C. [illegible] Registrar

Plot 12 N.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/13/1927 to 4/18/1927

that I last saw h[illegible] alive on 4/18/1927, 19

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows

Diabetes

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Signs

(Signed) W Wallace Wallis, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Humphrey DATE OF BURIAL April 22 1927

20 UNDERTAKER Lehmondt & Son ADDRESS 3617 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21381

CERTIFICATE OF DEATH

160

E 21381

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2004 W 39th St. St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell L. Patterson.

(a) RESIDENCE NO. 2004 W 39th St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12 1927

7 AGE	Years	Months	Days	IF LESS than I day hrs. or min..
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Albert E. Patterson

11 BIRTHPLACE OF FATHER (City or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret L. Dell

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Albert E. Patterson
(Address) 2004 W 39th St.

15 Filed C. HAMPSON JONES, M. D.
Registrar

APR 19 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15 1927 to April 17th 1927

that I last saw him alive on April 16th 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Fillet, M. D.

(Address) 7615 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Marys Hampden	April 19 1927

20 UNDERTAKER Thenowethson

ADDRESS 3615 Chestnut Ave.

Very Important. See Instructions on Back of Certificate

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 21382 — E 21382

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Mulliken ST. 6-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odessa Martin

(a) RESIDENCE NO. 1619 Mulliken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harve de Grace Md.

PARENTS

10 NAME OF FATHER: William Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harve de Grace Md

12 MAIDEN NAME OF MOTHER: Mary L Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harve de Grace Md

14 Informant: William Martin (Address) 411 S. Caroline St.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 1927 to April 17 1927, that I last saw her alive on April 16 1927, and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Tuberculosis (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) Dr Gulbransen M. D.

4/17 1927 (Address) 708 Lincoln St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harve de Grace Md

DATE OF BURIAL: 4/20 1927

20 UNDERTAKER: Byron & Wright

ADDRESS 218 N. Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

E 21383

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 21383

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltocity Hospital 6-9 Ward)

2-FULL NAME John M Nichols -

(a) RESIDENCE NO. 1524 Fairmount Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Demetta -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant _____

(Address) _____

9 1927 C. HAMPSON JONES, M. D.

1268 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1926 to April 15, 1927,

that I last saw him alive on April 15, 1927,

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cardiac End of Stomach

Duration mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? None

Did an operation precede death? No Date of March 10, 1927

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) _____ M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner Health

APR 19 1927

UNIVERSITY OF MARYLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21384

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Green St. 16-24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Stevens

(a) Residence No. 932 Boyd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: of Baby

6-DATE OF BIRTH (month, day and year): 4-11-27

7-AGE: .....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Henry Stevens

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Hattie Price

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant).....
(Address).....

15- Filed 9-1927 C. HAMPSON JONES, M. D. Per 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-11-27

17- I HEREBY CERTIFY, That I attended deceased from 4-11 1927 to 4-11 1927

that I last saw h.e.r alive on 4-11 1927

and that death occurred, on the date stated above, at 9 33 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Esa T. Dodge M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, | DATE OF BURIAL, ... 19....

20-UNDERTAKER, | ADDRESS

UNIVERSITY OF MARYLAND APR 19 1927

Spec.—1-12-23—M&T—500 Bks.

E 21385

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital — REGISTERED NO. 46257

CITY OF BALTIMORE: (No. Kayna and Dukeland ST. — WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Culp

(a) RESIDENCE NO. 526 Richwood Ave. Govans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Culp

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) A
(c) Name of employer A. G. Meyers Bro. & Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael S. Culp

11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)

12 MAIDEN NAME OF MOTHER Annie E. Holland

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Mary E. Culp
(Address) 526 Richwood Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D.
Per CRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/5 1927 to 4/19 1927,
that I last saw him alive on 4/19 1927,
and that death occurred, on the date stated above, at 3.55 A. m.
The CAUSE OF DEATH* was as follows:

Diabetic gangrene of Lt Leg

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of 4/13/27
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) Benjamin Miller, M. D.
, 19 (Address) W. 15. S. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Apr. 21 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W Lafayette St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21386 | CERTIFICATE OF DEATH | E 21386

101-091

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 819 E Eager St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wielepski

(a) RESIDENCE NO. 819 E Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S. if of foreign birth? 40 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Molly Wielepski

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than I day ..hrs. or ..min..
	55	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Molly Wielepski

(Address) 819 E Eager

Very important. See instructions on back of certificate.

9 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 13 1927 to Apr. 18 1927

that I last saw ~~him~~ alive on Apr. 17 1927

and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

4/19 1927 (Signed) C. H. Jones M. D.

(Address) 405 Bas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary 4/20 1927

20 UNDERTAKER — ADDRESS

William Gaelfond & Co 1618 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks. Stanley Gondrzejewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21387

CERTIFICATE OF DEATH.

101-001

E 21387

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley Gondrzejewski

(a) RESIDENCE NO. Pennington Av St. 719 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: 53 Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): 024

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Pete

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Anna Gondrzejewski

(Address) 719 Pennington Av

15 Filed APR 19 1927 By C. HAMPSON JONES, M. D. Registrar RRR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 17, 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

Signed Apr 17 1927 (Coroner) M. D.

(Address) 1637 Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

Date of Burial: April 20 1927

20 UNDERTAKER: F. W. Ozarowski

ADDRESS: 19-30 Eastern Av

Spec.—12 9-25—A Co.—200 Blks.

E 21388

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 30 90 REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Hrinecke

(a) RESIDENCE NO. 524 South Sharp St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867 May - 14

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Christoph Hrinecke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS Records

(Address) [redacted] C. HARRISON [redacted], M. D.

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1927, to April 18, 1927, that I last saw him alive on April 17, 1927, and that death occurred, on the date stated above, at 8:40 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Poper Smith, M. D.

April 19 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 4/21 19

20 UNDERTAKER Williams Bros. — ADDRESS 522 E Hoffman St

Spec.—12-9-25—A Co.—200 Bks.

E 21389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4-001

74 E 21389

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (~~JOHNS HOPKINS HOSPITAL~~ St., 79 Ward)

2-FULL NAME Perry Campbell

(a) RESIDENCE NO. Franklyn-W Va St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Great Va

(State or country)

PARENTS

10 NAME OF FATHER Wm Campbell

11 BIRTHPLACE OF FATHER (city or town) W Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary McCoy

13 BIRTHPLACE OF MOTHER (city or town) W Va

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed _____, 19____ C. HAMPSON JONES, M. D.

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1927

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to Apr 19, 1927, that I last saw him alive on Apr 19, 1927, and that death occurred, on the date stated above, at 4 am.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Franklin W. Va.

Did an operation precede death? yes Date of April 16, 1927

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) George S. Laing, M. D.

4/19/27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Keyser W Va — Date of Burial 4/19 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E Wash St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21390 92 E 21390

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital 16-67

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Nick Remmiger

(a) RESIDENCE NO. 767 Poplar Grove ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Bright 62

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Martin Remmiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madeline Kind

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Thomas Travers

(Address) 706 Eastlayson St

15 Filed 9 1927 C. HARRISON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1927, to Apr 18, 1927, that I last saw him alive on Apr-18, 1927, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Thomas B. Turner M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cemetery DATE OF BURIAL Apr 20 1927

20 UNDERTAKER George Schnaar ADDRESS 201 Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

21391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21391

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 N. Amm ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Thompson

(a) RESIDENCE NO. 220 N Amm ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: John Thompson

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: Approx 61; Months: —; Days: —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Viola Magruder Mourn see (Address): 221 N Amm St

15 9 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to April 17, 1927, that I last saw h[illegible] alive on April 17, 1927, and that death occurred, on the date stated above, at 1[illegible] p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 3 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Gatrury, M. D.

4/17 1927 (Address) 1129 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem DATE OF BURIAL: 4-20 1927

20 UNDERTAKER: Jas. J. Mc. Shimer ADDRESS: 1625 E. Monument st

Spec.—12-9-25—A Co.—200 Bks.

E 21392

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 24-34-47

City of BALTIMORE: (No. 1621 Marshall St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bennett.

(a) RESIDENCE NO. 1621 Marshall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of Gerhard Bennett

6 DATE OF BIRTH (month, day, and year): Dec 10 - 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: John J. Rossitu

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Mrs. Rossitus

(Address): 1621 Marshall.

9-1927 C. HAMPSON JONES, M. D.

Registrar

Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 4/18 - 27

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1927, to Apr 18, 19 27

that I last saw h[illegible] alive on Apr 17, 19 27

and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows: Uremic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Carcinoma of Breast + Cholelithiasis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) M. L. Luckett M. D.

4/19/27 (Address) 1717 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial 4/20 19 27

20 UNDERTAKER: J. Fenw McCully — ADDRESS 130 E. Front

Spec.—1-12-23—M&T—500 Bks.

(Munninge)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21393 E 21393

CERTIFICATE OF DEATH.

REGISTERED NO 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. (Street or Institution) 1-2 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Munnings

(a) RESIDENCE NO. 6765 Fleet St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Munnings

6 DATE OF BIRTH (month, day, and year): Jan 24 1864

7 AGE: Years 63 | Months 2 | Days 24 25 | If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse, Ot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Wm H. Langman

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Eliza Canfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant (Address): Frank H Davis 626 Eden Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-18-27 19

17 I HEREBY CERTIFY, That I attended deceased from 4-14, 1927, to 4-18, 1927.

that I last saw h W alive on 4-18, 1927.

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 4-14-27

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) Wm Cary Gaden, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem | DATE OF BURIAL: April 20 1927

20 UNDERTAKER: E. Howard Evans | ADDRESS: 356 Park Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21394

CERTIFICATE OF DEATH.

E 21394

1-PLACE OF DEATH

City of BALTIMORE: (No. Mrs Hospital St. 430 Ward)

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Gullivan

(a) RESIDENCE NO Laurel Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	77	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Artemus Sullivan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Hosey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Charles Mason

(Address) Laurel Md

9 1927 C. HAMPSON, REG'R M. D.

By RRR Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Acc

Fracture of Skull

(duration) yrs. mos. 12 hrs

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 12 hrs

Apr 19 27 (Signed) J. C. Yates M. D.

(Address) 143 W. Main (Current)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted if not at place of death? Laurel

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md Date of Burial April 19 27

20 UNDERTAKER Woodington & Fisher ADDRESS Laurel

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21395

CERTIFICATE OF DEATH.

12-33 12 9 E 21395

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 E. Montgomery St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger J. Dougherty.

(a) RESIDENCE NO. 114 E. Montgomery St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Martin Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Marie Kane

(Address) 114 E. Montgomery St.

15 4/19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1927 to April 16, 1927

that I last saw him alive on April 16 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chromic Nephritis ?

Acute Bronchitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Hanselman, M. D.

4/18/27 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/20 1927

20 UNDERTAKER J. J. Fahey & Sons

ADDRESS 1318 Light

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21396

CERTIFICATE OF DEATH.

49-002

E 21396

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1711 Thomas av. St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Dehringer

(a) RESIDENCE NO. 1711 Thomas av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia

6 DATE OF BIRTH (month, day, and year) March 1 1852

7 AGE — Years: 75 — Months: 1 — Days: 10 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ref. Locomotive

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ger.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ger

14 Informant Mrs Dehringer

(Address) 1711 Thomas av.

Filed ..... 19..... C. HAMPSON JONES, M. D.

9 1927 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7 1927, to Apr. 15 1927,

that I last saw h[im] alive on Apr. 12 1927,

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows: Senile Bronchitis with failing heart action. Acute edema of lungs

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Edmund M. D.

4/18, 1927 (Address) 1005 N. Howard av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial Newark N. J. April 2 1927

20 UNDERTAKER: Wm Cook ADDRESS 502 E. Baltimore.

Spec.—12-9-25—A Co.—200 Bks.

E 8962
E 21397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21397

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 79 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bruns

(a) RESIDENCE NO. Deep Creek Aze St. Ward Tennessee Penn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Mar - 1926

7 AGE: Years 1 | Months 13 | Days | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Grover Bruns —

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Date 9-1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1926 to April 18 1927, that I last saw her alive on April 18 1927, and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Xray

(Signed) Thomas B. Carnwath, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial April 21st 1927

20 UNDERTAKER: Geo. J. Roth — ADDRESS 1735 Harford Ave.

Very Important: See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

21398 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21398

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Sydenham Hospital ST., 6-17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Markoff

(a) RESIDENCE NO. 1828 N. Bond St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Godfrey Markoff.

6 DATE OF BIRTH (month, day, and year) April 28/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10 NAME OF FATHER Eby Steinbarger
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.
12 MAIDEN NAME OF MOTHER Elizabeth Riley
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Godfrey Markoff
(Address) 1828 N. Bond st.

15 Filed 9 1927, 19 [illegible] Registrar
Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to April 18, 1927, that I last saw her alive on April 18, 1927, and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:

Meningococcic Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Lumbar Puncture Date of
Was there an autopsy? No
What test confirmed diagnosis? Lumbar Punct. + Clinical

(Signed) Myron G. Tull, M. D.
4/19, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL April 20 1927

20 UNDERTAKER Geo. F. Pentz ADDRESS 1735 Harford ave.

Spec.—1-12-23—M&T—500 Bks.

E 21399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 21399

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4608 Culver ave ST. Lauriston WARD 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia A Romoser

(a) RESIDENCE NO. 4608 Culver ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, ~~or Divorced,~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Gustav Romoser

6 DATE OF BIRTH (month, day, and year): July 15 55

7 AGE: Years 71 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard Balt Md.

PARENTS

10 NAME OF FATHER: Geo. W. Matthews.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt.

12 MAIDEN NAME OF MOTHER: Virginia Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard.

14 Informant: Mrs. Clara McDonald.

(Address) 4608 Culver ave

15 Filed 9 1927, 19

C. HAMPSON JONES, M. D. Registrar

Per RHB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1927, to April 17th, 1927, that I last saw h alive on April 16th, 1927 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Endocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Sody, M. D. 4-7-1927 (Address) 421 S Hanford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: April 20 1927

20 UNDERTAKER: Geo. F. Rust

ADDRESS: 1735 Hanford

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21400 — CERTIFICATE OF DEATH — E 21400

24002

1-PLACE OF DEATH — REGISTERED NO. 13-59

City of BALTIMORE: (No. 2543 Madison Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gussie Schlichter Levin

(a) RESIDENCE NO. 2543 Madison Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mordecai S. Levin

6 DATE OF BIRTH (month, day, and year) About 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About 57	-	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Schlechter

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rosa Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mr. Saxon. (Address) 2543 Madison Ave.

91927 C. HAMPSON JONES, M. D. Registrar

Per RRW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19th. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1926, to April 19, 1927, that I last saw h[illegible] alive on April 19, 1927, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Saul Wolman, M. D.

, 19 (Address) 2444 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Baltimore Hebrew Cem. 4/21/ 1927

20 UNDERTAKER — ADDRESS

Harid Sondheim 118 20 W. Mt. Royal Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21401

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21401

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Spaeth

(a) RESIDENCE NO. 3504 Auchentoroly Ter. St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 46 mos. ds.

(If non-resident give city or town and State) Germany

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Spaeth

6 DATE OF BIRTH (month, day, and year) Sept. 3 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	54	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER David Bamberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Adler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Tracy Sonneborn

(Address) 3504 Auchentoroly

9 1927 C. HAMPSON JONES, M. D.

Per ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 12 1927, to Apr. 19, 1927, that I last saw h.e.r alive on April 19, 1927, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

Pulmonary infarction

(duration) ____ yrs. ____ mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) C. Hyman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. Date of Burial 4/21/1927.

20 UNDERTAKER David Goodkind ADDRESS 118 Lour St. Royal Ave.

very important. See instructions on BACK of Certificate.

Spec—12-23-21—E.B.P.S.—400 Bks.

E 21402

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

Registered No. E 21402

1-PLACE OF DEATH

City of BALTIMORE: (No. 1716 N. Carolina St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry W. Hoffman

(a) Residence No. 1716 N. Carolina St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Elizabeth Hoffman

6-DATE OF BIRTH (month, day and year) May 13/1840

7-AGE. 86

87 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Pa.

PARENTS.

10-NAME OF FATHER. Henry W. Hoffman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa.

11- (Informant) Rev. J. Luther Hoffman

(Address) 1716 N. Carolina St.

15- Filed ..... 19.. C. HAMPDEN JONES, M. D. Registrar.

R 20 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 14/27

17- I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1927 to Apr 17, 1927

that I last saw him alive on Apr 17, 1927

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ....yrs. ....mos. 1 ds

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 10 yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Anderson M. D.

19 (Address) 1716 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hartleton Pa.

DATE OF BURIAL. April 20, 1927

20-UNDERTAKER. George J. Ruth

ADDRESS 1735 Harford ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21403 ✓ E 21403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 306-E 23½ St. 12-50 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Dorsey

(a) Residence No. 306-E 23½ St. 2nd Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, B

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Dorsey

6-DATE OF BIRTH (month, day and year) unknown 1837

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER James Bryard

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Fannie Addison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Maggie Dorsey

(Address) 306 E 23½ St.

15- [illegible] AMPTON JONES, M.D.

APR 20 1927 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 17 1927

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926 to Apr 16 1927 that I last saw her alive on Apr 16 1927 and that death occurred, on the date stated above, at 10.0 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite (Duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Evidence

(Signed) R. Garland Dorsey M.D.

Apr 19, 1927 (Address) 1534-Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn	April 20, 1927
20-UNDERTAKER Mrs A. G. Elliott	ADDRESS 1725 Eastlander

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21404

CERTIFICATE OF DEATH.

10[illegible]-001

E 21404

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1217 Wilmer alley Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Carlton Pinder

(a) Residence No. 1217 Wilmer alley Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. C

5-Single, Married, Widowed, Divorced (Write which). Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) December 1894

7-AGE 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Balto (State or Country). Md.

PARENTS.

10-NAME OF FATHER. John Pinder

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Sarah Bailey

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Md.

14-

(Informant) Mary Pinder

(Address) 1217 Wilmer alley

15-

Filed APR 20 1927 192 HARRY JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17 27

17- I HEREBY CERTIFY, That I attended deceased from Mar 24 1927 to April 17 1927

that I last saw h[illegible] alive on April 16 1927

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Right side)

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Chandler M. D.

April 192 (Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Calvary	Apr 20 1927
20-UNDERTAKER.	ADDRESS
Mrs. R.G. Elliott	225 E Saratoga

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21405

CERTIFICATE OF DEATH

E 21405

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3810 Reisterstown Rd. St. 45-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Bourke

(a) RESIDENCE NO. 3810 Reistertown Rd. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 7 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	64	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward J. Bourke

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Virginia Wonn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Mrs. Francis G. Rosensteel

(Address) 3810 Reisterstown Rd.

15 Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

R 20 1927 Per RAK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927 19

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 19 27 to [illegible] 19 27

that I last saw h[illegible] alive on [illegible] 19 27

and that death occurred, on the date stated above, at 1 A. M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial Apl 22 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Dr Ingrone 2439 E Fairmount St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21406

CERTIFICATE OF DEATH.

E 21406

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 351 West 21 st ST. 12-51 WARD)

2-FULL NAME Frank J Welsh

(a) RESIDENCE No. 351 W 21st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13. 1926.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank J Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Castle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank J Welsh

(Address) 351 W 21st St

15 Filed APR 20 1927, 19. C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 19, 1927, that I last saw him alive on April 19, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Bonsman, M. D.

, 19 (Address) 1429 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lot Sales — DATE OF BURIAL Apr 20 1927

20 UNDERTAKER Nelson Cook — ADDRESS 502 E Madison

Cor.—12-9-25—A Co.—200 Bks.

E 21407

HEALTH DEPARTMENT—CITY OF BALTIMORE

6

CERTIFICATE OF DEATH.

90 E 21407

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 313 S. Sixth St. 26-37 Ward)

2-FULL NAME Washington Sapp.

(a) RESIDENCE NO. 313 S Sixth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5th 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Sapp

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Lena Diltz

(Address) 313 S. Sixth St.

15 Filed ..... 19 ..... Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. ..... ds.

Apr 20 27 (Signed) G C Glades M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial April 20 19 27

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21408

CERTIFICATE OF DEATH

101-001

E 21408

1-PLACE OF DEATH

REGISTERED NO. 15-61

City of BALTIMORE: (No. 2600 Elinor Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Grant Cromwell

(a) RESIDENCE NO. 2600 Elinor Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Heimiller Cromwell

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. & Ohio R. R.

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew J. Cromwell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Holliday

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs. Annie H. Cromwell

(Address) 2600 Elinor Ave.

15 Filed APR 20 1927 C. HAMPSON JONES M. D. Registrar

Per RRK

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-14-, 1927, to 4-18, 1927, that I last saw h[illegible] alive on 4-18, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse due to Chr. Endocarditis. - Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bilateral Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cecil K. Rheinpeel, M. D.

4/19, 1927 (Address) 2806 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial April 20, 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw Pl.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21409

CERTIFICATE OF DEATH

45 E 21409

1-PLACE OF DEATH

REGISTERED NO. 12-50

City of BALTIMORE: (No. 102-E-22nd.Street St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Olga Fennell

(a) RESIDENCE NO. 102-E-22nd.Street St. 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 37 yrs. 10 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B.Fennell

6 DATE OF BIRTH (month, day, and year) June-9-1889

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	37	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Bryantown

(State or country) Maryland

PARENTS

10 NAME OF FATHER John W.Wheatley

11 BIRTHPLACE OF FATHER (City or town) Bryantown

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Boardman

13 BIRTHPLACE OF MOTHER (city or town) Bryantown

(State or country) Maryland

14 Informant Mr.William B.Fennell. (husband)

(Address) 102-E-22nd.Street

15 Filed APR 20 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 19 27 to April 19 19 27

that I last saw her alive on April 18 19 27

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion.

(duration) yr. 2 mo. d.

CONTRIBUTORY (Secondary) Adeno Carcinoma

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? Date of Sept 6 1926

Was there an autopsy? no.

What test confirmed diagnosis? microscopical

(Signed) R L Kuyler M. D.

, 19 (Address) Uniontown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt.Olivet Cem. Washington, D.C.

Date of Burial 4-20 27

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W.NORTH AVE

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21410 90 E 21410

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 11-E-Chase-St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alcinda Cockayne McMechen

(a) RESIDENCE NO. 11-E-Chase-St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 84 yrs. 8 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Shepherd McMechen

6 DATE OF BIRTH (month, day, and year) August-16-1842

7 AGE	Years	Months	Days	1F LESS than 1 day ....hrs. or ....min..
	84	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Moundsville,

(State or country) W. Va.

PARENTS

10 NAME OF FATHER Vincent Lowe Cockayne

11 BIRTHPLACE OF FATHER (City or town) Moundsville

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Louise Johnson Lynn

13 BIRTHPLACE OF MOTHER (city or town) Fayette Co.

(State or country) Pennsylvania

14 Informant Mrs. Clifford G. Stokes (daughter)

(Address) 11-E-Chase-St., City.

15 Filed ....., 19.... Per ..... Registrar

C. HAMPSON JONES, M. D.

APR 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19th - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1927, to April 19th, 1927, that I last saw h.... alive on April 18th, 1927, and that death occurred, on the date stated above, at 8 00 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis Hypertension

(duration) 1 yrs. – mos. – ds.

18 Where was disease contrarted —

If not at place of death?

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Sym & symptoms

(Signed) J. A. Stallard, M. D.

(Address) 4/19 1927 100 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheeling, West Va. Date of Burial Apr-20/27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODER, Successor) ADDRESS 108 W. NORTH AVE.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21411 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21411

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secour Hospital ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Robert T. Smith, S. J.

(a) RESIDENCE NO. Evergreen College ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	38	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roman Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Honora McDonough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Stephen McDonough (Address) ----

15 Filed APR 20 1927 E. Raymond Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1927, to Apr 19, 1927, that I last saw him alive on April 18, 1927, and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Operation removal
Confirmed Appendicitis
P-neumonia (duration) yrs mos 14 ds

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes (Date of April 3 27

Was there an autopsy? No

What test confirmed diagnosis? usual ones

(Signed) E. J. Farley, M. D.

April 20, 1927 (Address) 915 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock, Md.	4/21 1927
20 UNDERTAKER Henry U. Myers & Son	ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

E 21412

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 25-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Goldsborough

(n) RESIDENCE NO. 332 Patapsco, Westport ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	16 4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Goldsborough

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Redelius

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mr. John Goldsborough (Address) 332 Patapsco St.

15 Filed APR 20 1927 19 C. HARRISON JONES, M. D. Registrar Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to April 19, 1927.

that I last saw her alive on April 19, 1927

and that death occurred, on the date stated above, at 11:05 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 14 ds

CONTRIBUTORY (Secondary) empyema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 15, 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Elizabeth Sherman, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL April 21 1927

20 UNDERTAKER Nelson E. Stiles

ADDRESS 231 Md. Ave Westport

Spec.—1-12-23—M&T—500 Blks.

E 21413 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21413

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 16-22-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John Gollery

(a) RESIDENCE NO. 1019 Woodley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gollery

6 DATE OF BIRTH (month, day, and year) Nov 14 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Elect. Business

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Virginia Alexandria

PARENTS

10 NAME OF FATHER Henry Gollery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary McConnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Gollery

(Address) 1019 Woodley St

15 Filed APR 20 1927 19.. H. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-15 1927, to 4-19 1927.

that I last saw him alive on 4-19 1927.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 3-26-1927

Was there an autopsy? No.

What test confirmed diagnosis? Operation & Clinical Signs

(Signed) A J Knapp. M. D.

4-19. 1927 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Apr 22 1927

20 UNDERTAKER McGinnis Carroll, Inc — ADDRESS 4103 Edgewood

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21414 — CERTIFICATE OF DEATH. — 31 — E 21414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 Columbia Ave 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maybelle Conway

(a) RESIDENCE NO. 755 Columbia Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6-DATE OF BIRTH (month, day, and year) Jan 16, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eliza Blizzard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Bodrew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William H Hastings

(Address) 755 Columbia Ave

15 Filed ....., 19.... C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 1, 1926, to Apr 18, 1927,

that I last saw her alive on Apr 18, 1927

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary tuberculosis & Pulmonary Fibrosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

+/(Signed) Bernard L. Lund, M. D.

19, 1927 (Address) 1717 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Apr. 21, 1927

20 UNDERTAKER Joseph Lyden — ADDRESS 1600 Mate Ave

TION is very important. See instructions on back of certificates.

20 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21415

CERTIFICATE OF DEATH.

E 21415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2414 E. Fairmount Ave. 6-10 Ward)

2-FULL NAME Ida Wachovsky

(a) RESIDENCE NO. 2414 E. Fairmount Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 41 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Moses Wachovsky

6 DATE OF BIRTH (month, day, and year): Nov 20 1868

7 AGE: Years 58 | Months 4 | Days 30 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Keeping house

(c) Name of employer ✓

9 BIRTHPLACE (city or town): .....

(State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Meislin

11 BIRTHPLACE OF FATHER (city or town): .....

(State or country) Russia

12 MAIDEN NAME OF MOTHER Esnesy Cohen

13 BIRTHPLACE OF MOTHER (city or town): .....

(State or country) Russia

14 Informant Moses Wachovsky

(Address) 2414 E. Fairmount Ave

APR 20 1927

Filed ..... 19..... Registrar

Per .....

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to April 19, 1927, that I last saw h.r. alive on Apl 16. 1927, 1927, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus. Stomach + Liver

(duration) Abt 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Typical Tests

(Signed) Henry C. Friedenwald, M. D.

Apr 20 1927 (Address) 1203 N. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Cem

Date of Burial: 4/22 1927

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E. Pratt St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 21416 (63)

90 E 21416

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Brady

(a) RESIDENCE NO. 400 Beale Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Richard Brady

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Julie Robins

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 20 1927 C. HAMILTON JOHNES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 12 1927, to Apr. 18, 1927, that I last saw h. alive on Apr. 18, 1927, and that death occurred, on the date stated above, at 11-10 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Emphysema Hypertension

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Milton Aberg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany Cemetery

Date of Burial: April 21 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1681 Orleans St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21417

CERTIFICATE OF DEATH.

70 E 21417

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 N. Monroe St., 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalia Henning

(a) RESIDENCE NO. 630 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Clarence H. Henning

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 31 | Months - | Days - | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Vincent Landwehr Deceased

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Mrs. J. LaDuke sister

(Address) 630 N. Monroe St

Filed APR 20 1927, 19 H. [illegible], Registrar.

or [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/27 19

17

I HEREBY CERTIFY, That I attended deceased from 4/6/27, 19, to 4/18/27, 19,

that I last saw h alive on 4/18/27, 19,

and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

Contributed

(duration) Thirty yrs. 5 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Bernard Fenig, M. D.

4/19/27 (Address) 1 West Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial 4/21 19 27

20 UNDERTAKER: Chas. H. Lechner & Jr. — ADDRESS 637 N. Paca St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Budres -

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21418

CERTIFICATE OF DEATH.

90 E 21418

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Granby St. 3-5 Ward)

2-FULL NAME John Budres -

(a) RESIDENCE NO. 1000 Granby St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 16 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No. 1878

6 DATE OF BIRTH (month, day, and year)

7 AGE 49 Years - Months	Days	IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania

(State or country)

PARENTS

10 NAME OF FATHER NO.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER NO.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant J.B.Frainor

(Address) 1918 E Fairmount Ave.

15 Filed R 20 1927 C. HAMILTON JONES, M. D. Registrar

Per RK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Mitral Stenosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Ed Laughon

(duration) ____ yrs. ____ mos. ____ ds.

Signed C E Yates M. D.

Apr 20 27, 19 (Coroner) (Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 21 27

20 UNDERTAKER John Greblianckas & Co. ADDRESS 423 S Paca St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21419

E 21419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S. Port St. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Eberling

(a) RESIDENCE NO. 819 S. Port St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. 9 mos. 10 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Eberling

6 DATE OF BIRTH (month, day, and year) July 3rd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 Years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pumpelstadt Germany

PARENTS

10 NAME OF FATHER Henry Eberling

11 BIRTHPLACE OF FATHER (city or town) Pumpelstadt (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Christmann

13 BIRTHPLACE OF MOTHER (city or town) Welders (State or country) Germany

14 Informant Mrs. Carrie Wood (Address) 819 S. Port St.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. . 1926 . to April 19 . 1927 . that I last saw him alive on April 17 . 1927 . and that death occurred, on the date stated above, at 12.55 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettekin M. D.

(Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Cemetery — DATE OF BURIAL April 22-27

20 UNDERTAKER Frederick Boarman Sons — ADDRESS Baltimore

TION is very important. See instructions on back of certificate.

FEB 26 1927 C. HAMPTON MILLER Registrar

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21420

CERTIFICATE OF DEATH.

E 21420

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Myrtle Av ~~St.~~ 4-76 WARD)

2-FULL NAME Joseph Williams

(a) RESIDENCE No. 228 Myrtle Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene A. Williams

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) L. I. Co.

(c) Name of employer M & M P. S. Co.

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Irene A. Williams (Address) 228 Myrtle Av

15 Filed APR 20 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 1927, to April 16th, 1927, that I last saw him alive on April 11th, 1927, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Ascending Paralysis (duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Embolus (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Examination

(Signed) Edward Earl Mackenzie, M. D.

April 19th, 1927 (Address) 1329 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL April 20/1927

20 UNDERTAKER James Eakin ADDRESS 914 Eutaw

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 21421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 21421

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1123 Warner St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Brown

(a) RESIDENCE NO. 1123 Warner St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Brown

6 DATE OF BIRTH (month, day, and year): Unk

7 AGE: Years 50 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Isiah Wright

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Howard Brown 1123 Warner St.

APR 20 1927

[illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/18/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/15/ 1927 to 4/18/ 1927

that I last saw her alive on 4/18/ 1927 and that death occurred, on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Renal Congestion

(Fatal?) (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. Buckley M. D.

4/19/ 1927 (Address) 908 Shaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: April 22/27

20 UNDERTAKER: David Easton ADDRESS: Cem

Of the items in plain type, at least one must be answered in every case, as they are very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21422

CERTIFICATE OF DEATH.

90 E 21422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1512 Rose St (ST.) 6-16 (WARD)

2-FULL NAME Henry Bantz Sr

(a) RESIDENCE NO. 1512 Rose St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs 6 mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Scholz

6 DATE OF BIRTH (month, day, and year) 04 18 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas. Elect. Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Bantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Henry Bantz Sr (Address) 1512 Rose St.

MAR 20 1927 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14 1927 to April 18 1927

that I last saw him alive on April 18 1927 at 4.30 P M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Rheumatic)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John Saunders M. D.

(Address) 900 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a. L. Co

DATE OF BURIAL April 21 1927

20 UNDERTAKER Chas L. Stevens

ADDRESS 1501 E Fort Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21423

CERTIFICATE OF DEATH.

129

E 21423

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bon Secour Hospital 16-22 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A Barringer

(a) RESIDENCE NO. 801 N Payson St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: S. Agnes Honoran

6 DATE OF BIRTH (month, day, and year): Sept 1 1861

7 AGE — Years: 65 | Months: 7 | Days: — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R Co

(c) Name of employer

9 BIRTHPLACE (city or town): W Va

(State or country)

PARENTS

10 NAME OF FATHER: Frank Barringer

11 BIRTHPLACE OF FATHER (city or town): W Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Glassford

13 BIRTHPLACE OF MOTHER (city or town): W Va

(State or country)

14 Informant: Frank Barringer

(Address) 801 N Payson St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

Per .....

R 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-17-27

17

I HEREBY CERTIFY, That I attended deceased from April 14 1927 to April 17 1927, that I last saw h.. alive on April 17 1927 and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj McCleary, M. D.

4/17 1927 (Address) 400 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk. Date of Burial 4/20 1927

20 UNDERTAKER: L. J. Galloway Sons ADDRESS 814 E Fayette St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21424 90 E 21424

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 1-12 WARD)

2-FULL NAME Mrs Josepline Hodek

(a) RESIDENCE NO. 809 N. Bedford. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James. Hodek.

6 DATE OF BIRTH (month, day, and year) March 13-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	49	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Soder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland -

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Frank. Blaback
(Address) 1418 N. Milton Ave

15 [illegible] C. HARRISON JONES, M. D.
Registrar

R 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 18, 1927, that I last saw her alive on April 18, 1927, and that death occurred, on the date stated above, at 10½, 20p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? None.

What test confirmed diagnosis? Clinical.

(Signed) Clement K. Monroe, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL [illegible] 1927

20 UNDERTAKER Ford Funeral Home ADDRESS Woodland

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-002

E 21425

E 21425

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 4608 Towanda Ave St. or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Binswanger Jr

(a) RESIDENCE NO. 4608 Towanda St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8 1925

7 AGE	Years	Months	Days	IF LESS than I day ..hrs. or ..min..
	2	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm Binswanger Sr

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Odette McNamara

13 BIRTHPLACE OF MOTHER (city or town) Fairmount Md

(State or country)

14 Informant Mr William Binswanger

(Address) 4608 Towanda Ave

15 Filed APR 20 1927 C. HAMPSON JONES M. D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1926 to April 19 1927

that I last saw him alive on April 18, 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus (Tuberculous)

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Creatinia Cretin

(duration) 2 yrs. 2 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Type of Marasmus

(Signed) Walter J Bacon M. D.

(Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Good Luck Cemetery — Date of Burial April 21 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly Classified. Every statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

21426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 21426

1-PLACE OF DEATH Md. General Hosp. REGISTERED NO. 46-37

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada. J. Hill

(a) RESIDENCE NO. 531 S. 12th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of George

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co
(State or country) Md.

PARENTS

10 NAME OF FATHER George Still

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Eliz Frank

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Hosp. Chart
(Address)

20 1927 C. HAMPSON JONES, M. D.
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1927, to 4/20, 1927, that I last saw her alive on 4/20, 1927, and that death occurred, on the date stated above, at 3 50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of abdominal cavity

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction & Cachexia (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4/18/27

Was there an autopsy? No

What test confirmed diagnosis? Question

(Signed) Jno A Tompkins M. D.
, 19 (Address) Mt Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL April 30 27

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21427

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3204 Fait ave St. 26-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George N. Hendley

(a) RESIDENCE NO. 3204 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Feb 8-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Arthur A. Hendley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Sofehia Ampteda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Sofehia Hendley
(Address) 3204 Fait ave

15 Filed 4 20 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 3 1927 to Apr 19 1927.

that I last saw him alive on apr 19 1927

and that death occurred, on the date stated above, at 6 30 A m

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia (Acute)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) No

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? All Sup of Pneumonia

(Signed) L Stanton, M. D.

4/20 1927 (Address) 3015 Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL April 21 1927

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E Eager st

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21428

CERTIFICATE OF DEATH.

90 E 21428

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 Brice St. 20-27 Ward)

2-FULL NAME Katherine Demuth

(a) RESIDENCE NO. 427 N. Brice St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Demuth

6 DATE OF BIRTH (month, day, and year): Sept 15 1846

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	80	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Hungaria

PARENTS

10 NAME OF FATHER: Peter Gerberts

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Hungaria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Hungaria

14 Informant: John Hens

(Address): 427 N. Brice St.

20 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1927, to Apr 20 1927, that I last saw h... alive on Apr 20 1927, and that death occurred, on the date stated above, at 10.42 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocard' tis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) J. W. Thomas, M. D.

Apr 22 1927 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial: Apr 22 1927

20 UNDERTAKER: Chas. W. Dill. ADDRESS 3109 Frank, Ave.

OF DEATH in plain terms, so that a copy of certificates very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21429

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21429

CERTIFICATE OF DEATH.

12-51 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U. S. Marine Hospital (Street) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Graff

(a) RESIDENCE NO. 625 Fifty First Street, (Street) (WARD) New York City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) S/S Wilsolo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records (Address)

15 Filed 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927, to April 19, 1927, that I last saw h— alive on April 19, 1927, and that death occurred, on the date stated above, at 9 30 A - m.

The CAUSE OF DEATH* was as follows:—

Pulmonary tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings + tubercle bacilli

(Signed) Wm. H. Wilson, M. D.

4 19, 1927 (Address) A.A. Surgeon U.S.P.H.S. U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	Apr 24 1927
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	1258 North Ave

Spec.—12 [illegible] —200 Blks.

E 21430

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21430

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 Walnut ave St., Woodlyn

2-FULL NAME Pauline D. Myers

(a) RESIDENCE NO. 600 Walnut Lane St. Ward 27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick Myers

6 DATE OF BIRTH (month, day, and year) May 18 1883

7 AGE — Years: 43 — Months: 11 — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER George Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Brooks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Fredrick Myers

(Address) 600 Walnut Ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4 1927, to April 19, 1927, that I last saw h[illegible] alive on " 15 1927, and that death occurred, on the date stated above, at 2:55 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Nephritis

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

4/19/27 (Address) 4055 Pat Pka.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — Date of Burial April 22 1927

20 UNDERTAKER Kendell Dappelston — ADDRESS 37 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Fill statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21431

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21431

CERTIFICATE OF DEATH.

16-22 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N. Fulton Avenue ST. 16 WARD)

2-FULL NAME Gilman P. Evans, M. D.

(a) RESIDENCE NO. 833 N. Fulton Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie L. Guyton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	67	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of Industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Theresa New York

PARENTS

10 NAME OF FATHER Gilman P. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER ----- Kelcey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs. Elizabeth G. Bell

(Address) 508 Franklin Terrace

15 20 1927 C. HAMPSON JONES, M. D. Registrar

Per RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1926, to April 18, 1927, that I last saw him alive on April 18, 1927 and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. E. Shannon, M. D.

, 19 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 4/21, 19 27

20 UNDERTAKER Henry A. Meats & Sons

ADDRESS 505 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21432

161-002

E 21432

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 S Belnadle St. 173 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo-T-Buggieski

(a) RESIDENCE NO. 805 S Belnord Ave St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 4-13-27

7 AGE: Years — Months — Days: 7 — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General natura of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Bernard Buggieski

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Agnes Hoppe

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto Md

14 Informant: Bernard Buggieski

(Address): 805 S Belnord Ave

15 Filed 4-21 1927 C. HAMPTON JONES, M. D. Registrar

Per RSC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-20 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to April 20, 1927, that I last saw him alive on April 20, 1927, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Infantile meningeal haemorrhage, occuring during labor.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

4-20. 1927 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St Mary's Cem	4-21 1927
20 UNDERTAKER	ADDRESS
Eugene Palmieri	City

Be sure that DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21433

CERTIFICATE OF DEATH.

129 E 21433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 Diller Ave ST., 27-41 WARD)

2-FULL NAME Anna Zeis

(a) RESIDENCE NO. 16 Diller Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Joseph Zeis

6 DATE OF BIRTH (month, day, and year): 25 April 1882

7 AGE: Years 44 Months 11 Days 25

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: Frank Zeis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Barbara Kantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Joseph Zeis

(Address): 16 Diller Ave.

15 Filed APR 21 1927, 19 Per

CHAS. P. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1926, to April 20 1927, that I last saw h alive on April 20, 1927, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerular Nephritis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood

(Signed) B. F. Donella, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer cem.

DATE OF BURIAL: April 23 1927

20 UNDERTAKER: August Pasch.

ADDRESS: 2402 ashland ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15 21434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 1 2001 L 21434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Linden ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Gholson

(a) RESIDENCE No. 1013 Linden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): 4-17-27

7 AGE — Years — Months — Days — If LESS than 1 day, 7 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Thomas Gholson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Edith Hatchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant

(Address)

15 Filed 27 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-17 1927

17

I HEREBY CERTIFY, That I attended deceased from 4-17, 1927, to 4-17, 1927,

that I last saw h[illegible] alive on 4-17, 1927,

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Premature by

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eva F. Dodge M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Univ. of Md.

20 UNDERTAKER

DATE OF BURIAL 19

ADDRESS

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 21435 — REGISTERED NO. **E 21435**

1-PLACE OF DEATH

City of BALTIMORE: (No. 1734 McCulloh St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Glover

(a) RESIDENCE NO. 1734 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 1902

7 AGE — Years: 25 — Months: 3 — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Alfred Glover

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Lillie Giffin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Lillie Glover

(Address): 1734 McCulloh St.

15 Filed: APR 21 1927

16 HAMPSON JONES, M. D. Registrar

Per R. K.

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day and year): April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to April 18, 1927, that I last saw him alive on April 16, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N. Y. City

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

4/19, 1927 (Signed) H S McCard, M. D.

(Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: 4/21/1927

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 Druid Hill Ave

(If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21436

CERTIFICATE OF DEATH.

24-001.

E 21436

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 822 N Carrollton ave Presbyterian Home of Maryland Ward) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Chapman

(a) RESIDENCE NO. 822 N Carrollton ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 11 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry R. Chapman

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Helen G. Thompson

(Address) 2709 Edmondson ave

15 Filed. 19 C. HAMILTON JONES, M. D. Registrar

APR 21 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14 1927, to April 20, 1927, that I last saw her alive on April 19, 1927, and that death occurred, on the date stated above, at 2 40 a m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Dx

(Signed) F. M. Lundquist M. D.

4/20 1927 (Address) 826 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Date of Burial April 22 1927

20 UNDERTAKER: Chas. J. Black ADDRESS 742 W. North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21437

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21437

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH Christs Institution Hospital 29 REGISTERED NO.

CITY OF BALTIMORE: (No. 704 Ensor St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Fritz

(a) RESIDENCE No. 526 Scott St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip. Fritz

6 DATE OF BIRTH (month, day, and year) Oct 26 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER John. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Philip. Fritz (Address) 526 Scott St

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7 1927 to April 18 1927.

that I last saw her alive on April 18 1927.

and that death occurred, on the date stated above, at 12. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with Hemiplegia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteris Sclerosis.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Dr. G. W. Lesser, M. D.

4/19 1927 (Address) 704 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Apr 21 1927

20 UNDERTAKER Jos Joerdens Son ADDRESS 217 S. B...

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21438 — 1-PLACE OF DEATH

129 ✓ E 21438 — REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Rosen

(a) RESIDENCE NO. 1716 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Rosen

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or....min.
	58	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Houswork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Joseph Rosen

(Address) 1716 N. Monroe St.

15 Filed APR 21 1927 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/1927

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 20, 1927, that I last saw her alive on March 20, 1927, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with uraemia

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Urine & Blood Examination

(Signed) Philip Faroy, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

German Hill & North Point Rd. 4-21-1927

UNDERTAKER — ADDRESS

Jack Lewis, 1439 E. Balto.

OCCUPATION is given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21439

CERTIFICATE OF DEATH.

17 E 21439

1-PLACE OF DEATH Md. Gen. Hosp. 20-21 REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Moshkevich

(a) RESIDENCE NO. 423 Norman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. Moshkevich.

6 DATE OF BIRTH (month, day, and year) Feb ? 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W. (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Saras

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ester ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Hospital Chart.

(Address)

15 Filed APR 21 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/11, 1927, to 4/20, 1927, that I last saw her alive on 4/20, 1927, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Gangrenous Cholecystitis

Gangrenous Appendicitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4/20/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation.

(Signed) [signature], M. D.

, 19 (Address) [illegible] Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lloyd Street Cem

DATE OF BURIAL 4-21- 1927

20 UNDERTAKER Jacob Levin

ADDRESS 1439 E. Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21440 E 21440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Aged Home REGISTERED NO. 13-59 74001

CITY OF BALTIMORE: (No. 110 Augusta St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Altshul

(a) RESIDENCE NO. 727 Newington Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benny Altshul

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Will Altshul

(Address) 727 Newington Ave.

15 Filed ..... 19 ..... HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from April 20th, 1921, to April 20th, 1921, that I last saw her alive on ~ ~ 19 and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L Lubsenow, M. D.

19 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodmansides, Hebrew Mt. Carmel	4-21-1921

20 UNDERTAKER Post Levin, ADDRESS 1439 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 1927

Cor.—12-9-25—A Co.—200 Bks.

E 21441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21441

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 S. Rose St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Blachowicz

(a) RESIDENCE NO. 710 S Rose St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Blachowicz

6 DATE OF BIRTH (month, day, and year) Dec 15 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer Borough Chemical Co

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER John Blachowicz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mary Szczola

(Address) 710 S Rose St

15 Filed APR 21 1927 C. HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~autopsy~~ Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis following Erysipelas

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart. Sudden

(duration) yrs. mos. ds.

(Signed) James M. Benton M. D.

(Coroner)

4/20 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St Stanislaus April 23 1927

20 UNDERTAKER ADDRESS

George A. Weber 2205 Bank St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21442

CERTIFICATE OF DEATH.

44 E 21442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 149 N. Potomac ST. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Heim.

(a) RESIDENCE NO. 149 N. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma T.

6 DATE OF BIRTH (month, day, and year) Oct 29-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beef Packer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T. Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Stuckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Emma T. Heim

(Address) 149 N. Potomac St

15 Filed APR 21 1927 19 C. HAMILTON JONES, M. D. Registrar

Per KR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3 1927 to April 20 1927

that I last saw her alive on April 19 1927

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Chas A. Heim, M. D.

April 21 1927 (Address) 402 S Potomac

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Gen. Evang Cem.

DATE OF BURIAL April 23 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. ATTENTION is very important. See instructions on back of certificates.

Cor.—13-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21443

E 21443

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 22 Reding Court. St. 23-33 Ward)

2-FULL NAME Annie Smith.(C)

(a) RESIDENCE NO. 22 Redding Court. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	Colored	Married.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William H. Smith.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Reed.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Carrie Rhodes.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co. Md.

14 Informant Helen Anderson.(C) sister

(Address) 726 N. Fairmount Ave.

Filed APR 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. M. Reinhardt M. D.
(Coroner)

4/18 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

Date of Burial April 21 1927

B. UNDERTAKER Joseph A. Lively.

ADDRESS 409 N. Mount Street.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21444

CERTIFICATE OF DEATH.

57 E 21444

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N. Linwood ave ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira B. Pitts

(a) RESIDENCE NO. 818 N. Linwood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Charles L Pitts

6 DATE OF BIRTH (month, day, and year) Jan 27th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Angelina Whitaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Charles L. Pitts

(Address) Cockeysville Md

15 Filed APR 21 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1926 to April 20 1927 that I last saw h alive on April 19 1927 and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Bronzed

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elmer Bateman, M. D.

4/20 1927 (Address) 717 N Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jessops M.E. Cemetery Pat ave DATE OF BURIAL Apr 23rd 1927

20 UNDERTAKER George Schilling & Sons ADDRESS N26 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21445 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21445

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 S. Brunswick ST 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Charles Gordon

(a) RESIDENCE NO. 531 So. Brunswick ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 9/10-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Harry Kingsmore
(Address) 531 S Brunswick St

15 Date APR 21 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927 to April 20-1927.
that I last saw him alive on April 20-1927,
and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical Diag.

(Signed) E Kelly Hammond M. D.

4/21, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westerny Cemetery DATE OF BURIAL Apr. 22 1927

20 UNDERTAKER George L. Schmidt & Son Eutaw & Lanvale Sts ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21446 E 21446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Calhoun ST. 1927 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Marceline Hollis

(a) RESIDENCE No. 300 N. Calhoun ST., WARD Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE: Years 32; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Raymond Stokes 300 N. Calhoun St.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1927, to 4-19, 1927,

that I last saw her alive on 4-19, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Putrid endometritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia — acute

Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ira T. Dodge M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clair Sub

DATE OF BURIAL: April 22 27

20 UNDERTAKER: Edward O'Rourke

ADDRESS: 5 N Castle

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

E 21447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21447

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 Myrtle ave (St.) (Ward) 17-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Williams

(a) RESIDENCE. NO. 929 Myrtle ave ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Henry Williams

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid of all work

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Isiah Wms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Mamie Dutton (mother)

(Address) 929 Myrtle ave

15 Filed APR 21 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Apr 18, 19 27.

that I last saw h alive on Apr 17, 19 27.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis (primarily uterine)

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1-2 M.W.

Did an operation precede death? yes Date of June 1926

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Opr.

(Signed) Chas. J. Keller M. D.

4/24, 19 27 (Address) 722 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 4/21 19 27

20 UNDERTAKER Samuel C. Brusley

ADDRESS 1325 Edmondson Ave

CAUSE OF DEATH to be filled in plainly, so that it may be properly coded. Every question must be answered. TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21448

CERTIFICATE OF DEATH.

90 E 21448

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 N Schroeder St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jackson Henderson

(a) RESIDENCE NO. 109 N Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): North Carolina

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Lucy Johnson

(Address): 109 N Schroeder

15 Filed APR 21 1927 C. HAMPTON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to April 18, 1927, that I last saw h..... alive on April 17, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Pulmonic Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Hoowood, M. D.

April 19 (Address) 939 or Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial: April 21 1927

20 UNDERTAKER: Samuel S. Brusley

ADDRESS: Mt Auburn

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21449 — 129 — E 21449

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 200 Federal St. 17-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Neale

(a) RESIDENCE NO. 200 Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Neale

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE — Years: 45 — Months — Days — IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Louis Chase

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Auburn

14 Informant: Lida Hutchins

(Address): 203 N. 33rd St. City

APR 21 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 6 1927 to Apr 16 1927

that I last saw h— alive on Apr 16 1927

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Apr 20. 1927 (Address) 1534 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. — Date of Burial: April 21 1927

20 UNDERTAKER: Samuel Stansbury — ADDRESS: 5789 Reade

Item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21450

CERTIFICATE OF DEATH.

100 E 21450

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Rosedale Terrace WARD) 20-70

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Thomas Gately

(Residence in Baltimore: No. 416 Rosedale Terrace St.: ....yrs.. mos. ..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, January 28, 1921.
(Month) (Day) (Year)

7-AGE, 21 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Bernard P Gately

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Lyan.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard P Gately

(Address) 416 Rosedal Terrace

15-

Filed APR 21 1927 191 C. HAMPSON JONES, M. D. Registrar.

Per R.K.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18 1927. to April 19 1927. that I saw h— alive on April 19 1927. and that death occurred, on the date stated above, at 12 Nov m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. Lorin Joslin M. D.

April 21, 1927. (Address) 1011 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. April 21, 1927.

20-UNDERTAKER F. A. Kramer & Son

ADDRESS 703 Hanover St

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21451 — REGISTERED NO. E 21451

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellsworth Z. Schreck

(a) RESIDENCE NO. 32 Township Rd. Dundalk St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....mns.
		6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Dundalk Md.

PARENTS

10 NAME OF FATHER Robert Schrack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER Blanche Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Phila., Md.

14 Informant Robt. Schreck

(Address) Dundalk Md

Filed....., 19..... (Signature) Registrar

APR 21 1927 C. HAMPSON JONES M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Purulent Pleurisy

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Gallen M. D.

(Coroner)

4/20/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norristown P. A. Date of Burial Apr 22 1927

20 UNDERTAKER John Lilliers ADDRESS 28 E. Evans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21452

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH found floating in the water off Pier #6 Locust Point — REGISTERED NO. 82

City of BALTIMORE: (No. ____ St. 94-35 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph E. Broh.

(a) RESIDENCE NO. Do not know. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hollenback, Pa.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Wm. E. Severe.

(Address) U. S. Veteran Bureau, Ft. McHenry

15 Filed APR 27 1927 C. HAMPSON JONES, M. D. Registrar Per ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found floating April 16, 1927 19__

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning, probably accidental.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ____

(duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Leonhardt M. D. (Coroner)

4/20 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — Date of Burial 4/21 19 27

20 UNDERTAKER Sol Levinson & Bro. — ADDRESS 1127 E. Baltimore St.

Do not write in this space. Any abbreviations used must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21453

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. 7-12 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Davidson

(a) RESIDENCE NO. 815 W. Chester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of: Widowed Wm H. Davidson

6 DATE OF BIRTH (month, day, and year): Sept - 1873

7 AGE: Years 53 54; Months 7; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Maryland

PARENTS

10 NAME OF FATHER: Martin Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Laura Mosberger Cambridge Md.

15 Filed ..., 19... THOMPSON JONES, M. D., Registrar

R 2 1 1927 Per RC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/20/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/4/27, 19, to 4/20/27, 19, that I last saw her alive on 4/20/27, 19, and that death occurred, on the date stated above, at 7.35 ~~Pm~~ m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Myocardial Failure

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary): Coronary Embolism

(duration) Sudden ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J.S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge, Md.

DATE OF BURIAL: 4/22/ 1927

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 250 Ed. Ave

CAUSE OF DEATH to plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21454 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21454

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Bon Secours Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (NO. 28-21 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John C. Rose

(a) RESIDENCE NO. 4909 Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Rose

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) England

PARENTS

10 NAME OF FATHER Joseph Rose

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) England

12 MAIDEN NAME OF MOTHER Mary Thackery

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) England

14 Informant Mrs. Ida D. Rose (Address) 4909 Edmondson Ave

15 Filed C. HAMPSON JONES, M. D. Registrar Per RAH

21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to April 21, 1927, that I last saw him alive on April 20, 1927, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Chronic Interstitial Nephritis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 23, 1927
20 UNDERTAKER	ADDRESS
John C. Mitchell & Son 1900	Eutaw Place

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Norris ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21455 E 21455

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 611 Glenwood (ST.) 13-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lauan Harlington Norris

(a) RESIDENCE NO. 611 Glenwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John B. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane A. Bacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Bennet B. Norris

(Address) 2430 N. Calvert St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/6, 1925, to 4/20, 1927, that I last saw h-e alive on 4/20, 1927, and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic Interstitial Nephritis
Arteriosclerosis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 611 Glenwood St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack. C. Horgan, M. D.

4/20, 1927 (Address) 62 Black St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 23, 1927
20 UNDERTAKER	ADDRESS
John O. Mitchell & Son	1900 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21456

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Penitentiary Hospital St. 10 Ward) 15

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stein

(a) Residence No. Clayton Ohio St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Not known

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm Horse

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Clayton Ohio

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not known

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Med. Penitentiary

(Address) 454 Forest St

15- 4/7 1927 C. HAMPSON JONES, M. D. Registrar.

By [illegible]

1283

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6-1927

17- I HEREBY CERTIFY, That I attended deceased from March 3 1927 to April 6 1927

that I last saw him alive on April 6 1927

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

1 Arteriosclerotic Cardio-Vascular Renal

2 - Chronic Nephritis

(Duration) 8 yrs. mos. ds

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. 2 mos. ds

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Faudeson M. D.

4/6 1927 (Address) 454 Forest St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER, ADDRESS

APR 21 1927

THE MORGUE.

UNIVERSITY OF MARYLAND

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21457

CERTIFICATE OF DEATH.

E 21457

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Municipal Hosp

City of BALTIMORE: (No. 515 W Balt St 4 20 Ward)

2-FULL NAME Fred Phillips

(a) RESIDENCE NO. Not known St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Not known

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH: unknown

7 AGE: Years 35 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Jamaica

(State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant

(Address)

Filed 1927 C. HAMPSON JONES, M. D.

1281 Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Daniel A. Graham M. D.

(Coroner)

, 19 27 (Address) 332 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Remains sent to

UNIVERSITY OF MARYLAND

APR 21 1927

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATI... very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21458

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21458

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St. 10-15 Ward)

2-FULL NAME Richard Lindsay

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: 40 Months: about Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.)

I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Apr. 27 (Signed) W. F. Kelly M. D.

(Coroner)

, 1927 (Address) 163 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R2 1 1927

C. THOMPSON JONES M. D.

Registrar

1285

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21459

CERTIFICATE OF DEATH.

90 E 21459

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Near Market Place St., 4th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Gaffaney

(a) RESIDENCE NO. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	about		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 27, 19 Registrar

1286

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Apr 21 (Signed) (Coroner) M. D.

, 19 27 (Address) 1699 Bo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

tion should be carefully supplied. AGE should be stated
OF DEATH in plain terms, so that it may be properly c
very important. See instructions on back of certificate.

APR 21 1927 UNIVERSITY OF MARYLAND APR 21 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21460

REGISTERED NO. 170 E 21460

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 44 Market Space Ward H-6)

2-FULL NAME Lutkum - Douglas - John Jones

(a) RESIDENCE NO. 44 Market Space St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 4-27 1927 Registrar

1287

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Pistol Shot wound in heart (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

21 apt st (Signed) M. D.

, 1927 (Address) 1039 Bonaparte (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

For Wm. E. WOODALL

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21461

CERTIFICATE OF DEATH

E 21461

REGISTERED NO. 24001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2046 Linden Ave. St. 14 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa M. Eytinge

(a) RESIDENCE NO. 2046 Linden Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Eytinge

6 DATE OF BIRTH (month, day, and year) March 5th. 1851.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Gershon----------

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bavaria.

12 MAIDEN NAME OF MOTHER Betty Wexler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Guy Eytinge

(Address) 2046 Linden Ave.

15 Filed APR 21 1927 C. HAMPSON JONES, M. D. Registrar

Per ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20, 1927

April 20

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to April 20, 1927, that I last saw h alive on April 20 - 9 AM, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Melvin S. Lenthal, M. D.

, 19 (Address) 304 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem. Date of Burial 4/22/ 1927

20 UNDERTAKER Harid Sandheim ADDRESS 113 N. W. mt. Royal Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21462 E 21462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 W Lombard St., (ST.) 20-28 (WARD)

REGISTERED NO. 100,981

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret S. Norris,

(a) RESIDENCE NO. 1911 W Lombard St., ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A Norris

6 DATE OF BIRTH (month, day, and year) June 13, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John A Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Greenwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Joseph A. Norris 1911 W Lombard St.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20., 1927.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1927, to Apr. 20, 1927, that I last saw her alive on Apr. 20th, 1927, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Broncho-Pneumonia.

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. Etc.

(Signed) Chas. Norris, M. D.

Apr. 21. 1927. (Address) 8887 N. Rowland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Apr 23 1927

20 UNDERTAKER Harry H. Vitz & Co — ADDRESS 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 21

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21463 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21463

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 Hollins St 4-28 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles F. Tharle

(a) Residence No. 1733 Hollins St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single~~ Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine E. Tharle

6-DATE OF BIRTH (month, day and year) Nov. 2, 1852

7-AGE. 74 yrs. 5 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George W. Tharle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Louise Tharle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) Catherine E. Tharle

(Address) 1733 Hollins St

15-Filed APR 21 1927 C. HAMPSON JONES, M. D. Registrar.

Rec'd 4/21/27

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19, 1927.

17- I HEREBY CERTIFY, That I attended deceased from April 4, 1927 to April 19, 1927

that I last saw him alive on April 18, 1927

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Arterial Hypertension

Ch. Nephritis (Interstitial)

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure & edema of lungs (Duration) yrs. 15 mos. ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual signs.

(Signed) Geo. L. Wells M. D.

, 19 (Address) 1413 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. April 22, 1927

20-UNDERTAKER. Harry H. Wetzler ADDRESS 1231 Woodland Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21464

CERTIFICATE OF DEATH.

E 21464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S Ellwood Ave. ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose May Kellean

(a) RESIDENCE NO. 506 S Ellwood Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Kellean

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER --- Wardecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles F. Kellean

(Address) 506 S Ellwood Ave.

15 Filed APR 21 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 19 27 to April 19 19 27

that I last saw h alive on April 17 19 27

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Uraemia

C. P. Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) gall stones

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith M. D.

(Address) 4 700 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL April 22 1927

20 UNDERTAKER Harry H. Witzke

ADDRESS 531 W. Lombard St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

21465 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 21465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hospital

CITY OF BALTIMORE: (No. 418 N. Lexington ST. 25-64 WARD) 101-801

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hammond

(a) RESIDENCE NO. 4433 Alabama Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Bessie Hammond

6 DATE OF BIRTH (month, day, and year) Sept 10 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Building Trade

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Walter Hammond

(Address) 4433 Alabama Ave

15 Filed APR 21 1927, 19... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 19, 1927, that I last saw him alive on April 19, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Murdock, M. D.

, 19 (Address) 418 N. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL April 22, 1927

20 UNDERTAKER Harry H. Weitzle — ADDRESS 1531 Lexington St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21466

HEALTH DEPARTMENT—CITY OF BALTIMORE E 21466

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4162 Ardmore Way ST. 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgetta Everett

(a) RESIDENCE NO. 4162 Ardmore Way ST., 27 WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (~~Husband~~) of (~~Wife~~) WIFE of John Everett

6 DATE OF BIRTH (month, day, and year) 1847 Oct 8

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John Price

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mary Werner

(Address) 4162 Ardmore Way

15 Filed ... 1927 ... 19... (Name illegible) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 20, 1927, that I last saw her alive on April 19, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) over

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis Physical signs

(Signed) C. A. Bundick, M. D.

April 23 1927 (Address) 2221 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loyola Cem Md Mountain Cemetery — DATE OF BURIAL: Apl 27 1927

20 UNDERTAKER: Wilson Cook Sur Co Edmondson Av — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21467 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21467

CERTIFICATE OF DEATH.

REGISTERED NO. 4690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4507 Liberty Heights Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Frances Gilbert.

(a) RESIDENCE NO. 4507 Liberty Heights Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18th 1842

7 AGE Years 84 Months 10 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Aquilla Gilbert

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Frazier

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Charles W. Gilbert (Address) 4507 Liberty Heights Ave

15 Filed 19 HAMPSON JONES M. D. Registrar

By RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8 1925 to April 21 1927, that I last saw her alive on April 20 1927, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease (mitral regurgitation)

(duration) 2 yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) L. T. Shemwell M. D.

April 24, 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL April 23rd 1927

20 UNDERTAKER Putnam & Gore

ADDRESS 1723 W. Lafayette Ave

21 1927

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21468

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 4-1 (WARD)

REGISTERED NO. + 110

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lizzie Holbert

(a) RESIDENCE NO. Shinnston W. Va. ST., WARD Shinnston W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 1 mos. 7 ds. How long in U. S., if of foreign birth? 43 yrs. 8 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie I Holbert

6 DATE OF BIRTH (month, day, and year) Aug-21-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Road Work

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Marion Co, W. Va.

PARENTS

10 NAME OF FATHER Abraham Holbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Mollie I Holbert (wife)

(Address) Shinnston - W. Va.

15 C. HAMPSON JONES, M. D. Registrar

R2 1 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/16 1927 to 4/21 1927

that I last saw h[illegible] alive on 4/21 1927

and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Stricture of Esophagus

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Stomach Bowels Pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 3/7/27

Did an operation precede death? Yes Date of 4/13/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P Gilbert, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Shinnston W. Va. DATE OF BURIAL Apr 22 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Information should be carefully supplied. Any blank not filled in should be explained.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21469

E 21469

CERTIFICATE OF DEATH.

+43

1-PLACE OF DEATH University Hosp

CITY OF BALTIMORE: (No. 4-30 ST. or WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Beauchamp or Beauchamp

(a) RESIDENCE NO. Crisfield Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE: Mary Beauchamp

6 DATE OF BIRTH (month, day, and year): Apr 1860

7 AGE: 66 Years (67) | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Beauchamp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Boarman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Robert Beauchamp Crisfield Md

15 Filed ..... 19 ..... Registrar: C. HAMPSON JONES, M. D. Per RKH

R 2 1 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/21 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/6 1927 to 4/21 1927, that I last saw h.. alive on 4/21 1927, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Gen. Carcinomatosis

Primary Abdominal tongue

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure one week (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/15/27

Was there an autopsy? no

What test confirmed diagnosis? Micro. exam. of tissue removed

(Signed) J. S. Winslow M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md

DATE OF BURIAL: Apr 22 1927

20 UNDERTAKER: Harry H. Witzke

ADDRESS: 534 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21470

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21470

CERTIFICATE OF DEATH.

REGISTERED NO. 3

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1726 W Fenton ST. WARD) 17-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dollie Wyft.

(a) RESIDENCE NO. 1726 W. Fenton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen Wyft

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Major Dawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hannah Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Stephen Wyft

(Address) 1720 Fenton

15 Filed APR 22 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7th 1927 to April 19th 1927.

that I last saw h alive on April 19th 1927.

and that death occurred, on the date stated above, at 11:50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Following Influenza

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis M. D.

(Address) 727 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4-22-19 27

20 UNDERTAKER: John H. Foden

ADDRESS 1037 Edmondson Ave

N. B.—WRITE PLAINLY; all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21471

CERTIFICATE OF DEATH.

90 E 21471

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Anderson

(a) RESIDENCE NO. Preston + Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teddy Anderson

6 DATE OF BIRTH (month, day, and year) May 4th 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67 68	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER John O Brien

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Clarkson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St

APR 22 1927

C. HAMILTON JONES, M. D.

Per K.J.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 21st

17 I HEREBY CERTIFY, That I attended deceased from No Record 19.. to 19..,

that I last saw h.. alive on April 17, 19..,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D.

Apr 25, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — Date of Burial Apr. 22 1927

20 UNDERTAKER Bila Wiedefeld — ADDRESS 914 Gramont Ave

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21472

Calvin J Richardson

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 21472
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Otterbein St. 21-29 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin J Richardson

(a) RESIDENCE NO. 502 Otterbein St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Sing'l

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 15 1883

7 AGE — Years: 43 — Months: 4 — Days: 5 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shipbuilder
(b) General nature of industry, business, or establishment in which employed (or employer): Yard
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Balt

PARENTS

10 NAME OF FATHER: Joseph C Richardson

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Balt

12 MAIDEN NAME OF MOTHER: Anna Braun

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balt

14 Informant: Mrs Dora V Richardson
(Address) 507 Otterbein St

APR 22 1927

E. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/20/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis
Cerebral Hemorrhage
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

(Signed) Edward Atwater M. D.
(Coroner)
, 1927 (Address) 322 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — Date of Burial: April 23 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 21473

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓

E 21473
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3801 Greenmount Ave. 4-47 ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret C. Engel

(Residence in Baltimore: No. 3801 Greenmount Ave., St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb. (Month) 3 (Day), 1858 (Year)

7 AGE: 69 yrs. 2 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 31

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Edward C. Clayton

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Saulsbury

13 BIRTHPLACE OF MOTHER (State or country): Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. C. Lewis Engel

(Address) 3801 Greenmount Ave.

15. APR 22 1927 191 Hampson Jones, M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr. (Month) 20. (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 3 yrs. 191 . to. 191 .
that I saw h.. alive on Apr 20 - 1927.
and that death occurred, on the date stated above, at 11.20 p.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) about 3 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. G. Prentiss M. D.
Apr. 21, 1927 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: April 25, 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21474

CERTIFICATE OF DEATH.

E 21474

1-PLACE OF DEATH St Elizabeth Orphan Asylum

City of BALTIMORE: (No. Chesnut Hill ave. St., 9-47 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Nance

(a) Residence No. St Elizabeth Orphan Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 8 1926

7-AGE, yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Paul Nance

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Ida Nance

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), North Carolina

14- (Informant) Ida Nance

(Address) 706 East ave.

APR 22 1927 C. HAMPSON JONES, M. D.

Per Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20 1927

17- I HEREBY CERTIFY, That I attended deceased from April 18 1927 to April 20 1927

that I last saw him alive on April 20 1927

and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(with Convulsions)

(Duration) yrs. mos. 2 ds

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. mos. ds

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Ellerson M.D.

April 22, 1927 (Address) 1305 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: April 22-1927

20-UNDERTAKER: Herbert Johnson

ADDRESS 916 Eastern ave

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21475

CERTIFICATE OF DEATH.

38 E 21475

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., E WARD 29)

2-FULL NAME Annie Johnson

(a) RESIDENCE No. 738 W. Redwood ST., WARD E

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Black	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	48 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work In laundry

(b) General nature of industry, business, or establishment in which employed (or employer) In laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Dan Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Dan Howard (Address) 738 W Redwood St

15 APR 22 1927 G. HAMILTON JONES, M. D. Registrar

By R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 20 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-14 1927 to 4-20 1927.

that I last saw her alive on 4-19 1927

and that death occurred, on the date stated above, at 5 30 P M.

The CAUSE OF DEATH* was as follows:

Cardio vascular syphilis

(duration) unknown months

CONTRIBUTORY (Secondary) Internal Haemorrhage pacey

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 738 W. Redwood St.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) E. K. Miller, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 22/27
20 UNDERTAKER	ADDRESS
Dan'l Carlon	946 Fremont Ave.

MEDICAL EXAMINER SHOULD BE CAREFULLY APPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 21476
REGISTERED NO.

E 21476
1-PLACE OF DEATH

City of BALTIMORE: (No. 809 Harlem Ave St., 17-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Proctor

(a) RESIDENCE NO. 809 Harlem Ave St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Proctor

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER John McQuay

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Workman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Fannie McQuay
(Address) 1611 Druid Hill Ave

15 Filed APR 22 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

(Signed) J. T. Neal Jr., M. D.
(Coroner)

19 27 (Address) 1502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial 4/22 1927

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 163 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21477

CERTIFICATE OF DEATH.

E 21477 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 173 Falls Road St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David A. Williams

(a) RESIDENCE. NO. 173 Falls Rd St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Williams

6 DATE OF BIRTH (month, day, and year) ? 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John F Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Mary Williams
(Address) 173 Falls Road

15 Filed APR 22 1927 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 31, 1927, to June 17, 1927, that I last saw h[illegible] alive on June 17, 1927, and that death occurred, on the date stated above, at 11.40 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L A Chesdon M. D.

June 21, 1927 (Address) 117 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	6/22/1927

20 UNDERTAKER Mrs. Geo. E. Holland ADDRESS 632 Druid Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21478

CERTIFICATE OF DEATH

179 E 21478

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Edgewood Sanatorium S. 28-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Eugene Koons,

(a) RESIDENCE NO. 4703 Milford Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella F. Koons,

6 DATE OF BIRTH (month, day, and year) June 27, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	63	9	24 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager No 06

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Guilford Motor Co.

9 BIRTHPLACE (city or town)

(State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Elward Koons,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Mikesell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Ella F. Koons

(Address) 4703 Milford Ave.

15 Filed APR 24 1927 19 H. M. [illegible], Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 20 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 27. 19 26. to April 20. 19 27.

that I last saw h[illegible] alive on April 19, 19 27.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Uraemia

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clan Brunk M. D.

4/22. 19 27 (Address) 4708 Maryland Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial APR 23 1927 19

20 UNDERTAKER Geo W Little ADDRESS [illegible] EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21479

CERTIFICATE OF DEATH.

4-25 129

E 21479

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophie Leek

(a) RESIDENCE NO. 228 N. Paca St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with unfading ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Leek.

6 DATE OF BIRTH (month, day, and year): March 2nd 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Cap. John Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Schoenfeldter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: William Leek

(Address) 228 N. Paca St

APR 22 1927

Filed ..... C. HAMILTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to April 20, 1927, that I last saw h[illegible] alive on April 20, 1927, and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

&

Arteriosclerosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Mottas M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem.

DATE OF BURIAL: April 23 1927

UNDERTAKER: Wilbur W. Shriver

ADDRESS: 1018 Edmondson Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21480

CERTIFICATE OF DEATH.

Registered No. E 21480

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 Whitridge av St., 7-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Aubrey Beard

(a) Residence No. 309 Whitridge av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed,~~ or ~~Divorced,~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6-DATE OF BIRTH (month, day and year) Nov 10th 72

7-AGE. 54 yrs. 5 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) Md Casualty Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Geo Beard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Louise Beard

(Address) 309 Whitridge Av

APR 22 1927 HAMPSON JONES, M. D. Registrar.

Per R.K.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20, 1927.

17- I HEREBY CERTIFY, That I attended deceased from March 9th 1927 to April 20 1927

that I last saw h[illegible] alive on April 20 1927

and that death occurred, on the date stated above, at 12.15 pm

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(Duration) 5 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) T. H. Wyman M. D.

, 19 (Address) 1934 E. 31st St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk DATE OF BURIAL. April 22nd 19 27

20-UNDERTAKER. A. Jones ADDRESS 11 S. Gilmor

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21481

CERTIFICATE OF DEATH

161-81

E 21481

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 230 W. Hamburg St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Wallace

(a) RESIDENCE NO. 230 W Hamburg St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 4/13/27

7 AGE: Years Months Days: 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Percy Wallace

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Gross.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Percy Wallace

(Address) 230 W Hamburg St.

Filed APR 22 1927 H. HANSON JONES, M. D. Registrar

Per L.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/21/27

17 I HEREBY CERTIFY, That I attended deceased from 4/13/27 to 4/21/27, that I last saw him alive on 4/21/27, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Premature Labour

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Contracted Pelvis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Amy Bonley M. D.

4/21/27 (Address) 908 Shady Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery

Date of Burial: 4/22 19 27

20 UNDERTAKER: Walter B. Spriggs

ADDRESS: 139 W. Hamburg St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21482

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 21482

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Stricker Memorial Hospital ST., (or) WARD)

2-FULL NAME Marshall H. Hubbard

(a) RESIDENCE No. 702 E. 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hanna Donohue

6 DATE OF BIRTH (month, day, and year) 7/3/97

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Chas Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mrs. J. Marshall
(Address) 702 E. 36th St

15 Filed APR 22 1927 19 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH was as follows:

Tubercular Meningitis
Hours
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John H. Mosser, M. D.
(Coroner.)
4/21, 1927 Address 3932 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Apr 22 1927

20 UNDERTAKER Frank Ulrich ADDRESS 2008 Aisquith

Cor—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21483

CERTIFICATE OF DEATH.

3 E 21483

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward) 16-37

2-FULL NAME Arnold Rasmusson found - door Step at

(a) RESIDENCE NO. foot of Broadway St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Norwegian Ship

9 BIRTHPLACE (city or town)

(State or country) Norway

PARENTS

10 NAME OF FATHER Rasmusson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Norway

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Norway

14 Informant Dr. James M. Fenton.

(Address) 700 Chase st.

APR 22 1927 E. HAMILTON JONES, M. Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) James M Fenton M. D.
(Coroner)

4 20. 1927 (Address) 700 Chase st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death Balto City Hosp yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? found at foot Broadway on street

Former or usual residence unknown

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mount Carmel Cemetery April 22 1927

UNDERTAKER George L. Ruth ADDRESS 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21484

CERTIFICATE OF DEATH.

E 21484
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 W Franklin ST. 17-26 (WARD)

2-FULL NAME Kate Williams

(a) RESIDENCE NO. 813 W Franklin ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Williams

6 DATE OF BIRTH (month, day, and year): Aug 6 1874

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
52 53	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Adella Goode 813 Franklin St

15 Filed APR 22 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to April 18, 1927, that I last saw her alive on April 16, 1927, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast
(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Microscopic

(Signed) Wm. N. Wright, M. D.

4/18, 1927 (Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cy — DATE OF BURIAL: April 22 1927

20 UNDERTAKER: Leonard Wooden — ADDRESS: 308 N Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21485

CERTIFICATE OF DEATH.

169 E 21485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE; (No. Front Prin 4 Pratt St 9 Ward)

2-FULL NAME Ike Lebowitz

(a) RESIDENCE NO. 131 N. Ann Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Lebowitz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Lebowitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Morris Basch

(Address) [illegible]

APR 22 1927

[illegible] JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH 1927

16 DATE OF DEATH (month, day and year) Found 19 Apr. Instantaneous

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

Suicide by drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Apr. 22 (Signed) W. J. Ruley, M. D.

(Coroner)

, 1927 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrow Mt. Carmel — Date of Burial 4-22 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21486

CERTIFICATE OF DEATH.

118-002

E 21486

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 25-72 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Helen Mc Dermott

(a) RESIDENCE NO. St. Agnes Hosp. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	—	— —	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer): Rel.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): So Boston Mass

PARENTS

10 NAME OF FATHER Wm J McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country): So Boston Mass

12 MAIDEN NAME OF MOTHER Daley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): So Boston Mass

14 Informant: Sister - M. P. McDermott

(Address) St. Agnes Hospital

15 Filed APR 22 1927 19 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to April 21, 1927, that I last saw her alive on April 21st, 1927, and that death occurred, on the date stated above, at 11 07 a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency with generalized peritonitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

partial (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/16/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A. Theron Hunter, M. D.

4/22/1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL 4-23-27

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-901 E 21487

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 St. Paul St. St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline E. Hayward

(a) RESIDENCE NO. 903 St. Paul St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilbur T. Hayward

6 DATE OF BIRTH (month, day, and year): Aug. 21, 1866

7 AGE — Years: 60 Months: 8. Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: James E. Etheridge

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Carrie S. Hamby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Mrs. Caroline E. Craft

(Address): 903 St. Paul St.

15 Filed APR 23 1927, H. C. HAWLEY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April - 21 - 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16 1927 to April 21 1927 that I last saw h.. alive on April 21 1927 and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia - Lobar -

(duration) — yrs. — mos. 6 — da.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) C. Hawley Jones, M. D.

(Address) 1327 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: April 23, 1927

20 UNDERTAKER: John O. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21488

CERTIFICATE OF DEATH.

E 21488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 Pennsylvania Ave WARD)

2-FULL NAME Abraham Balbour

(a) RESIDENCE No. 2220 Pennsylvania Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Balbour

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Unknown

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Virginia

14 Informant (Address) Lillian Barbour 2220 Penna Ave

15 Filed APR 22 1927 C. HAMPSON JONES, M. D. Registrar Per RRL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to April 16, 1927, that I last saw him alive on April 20, 1927, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

Acute myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exa

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Apr 22 1927

20 UNDERTAKER D. Wm. R. A. Elliott

ADDRESS 725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21489 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 E 21489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N Bond St. 6-9 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Mean

(a) RESIDENCE NO. 420 N Bond St., Ward
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-6-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Walter Mean

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Kemp

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Walter Mean (father)
(Address) 420 N Bond St

15 APR 22 1927 C. HAMPSON JONES, M. D.
By [illegible] Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 19 27

17
I HEREBY CERTIFY, That I attended deceased from April 14 19 27 to 4/19 19 27.
that I last saw h[illegible] alive on 4/19 19 27.
and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)
(duration) yrs. mos 6 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) R. Lyburn, M. D.
4/20 19 27 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Apr. 23 19 27
UNDERTAKER Jno. C. Lokes	ADDRESS 1302 Jefferson

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21490

CERTIFICATE OF DEATH.

90 ✓ E 21490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 S. Dallas St., 34 Ward)

2-FULL NAME Annie Chambers

(a) RESIDENCE NO. 103 S Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of David Chambers

6 DATE OF BIRTH (month, day, and year) Jan. 22 1842

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	85	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Salt Lake

(State or country)

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Frederick Bartlett

(Address) 35 S Dallas

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis (chronic) & Emphysema

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Failing Compensation

(duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.

(Coroner)

April 21, 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BERIAL, CREMATION OR REMOVAL Laurel cemetery Date of Burial April 23 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans st

APR 22 1927

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21491

CERTIFICATE OF DEATH.

100-001

E 21491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 26 W. Lexington ST. 4-25 WARD)

2-FULL NAME Carroll N. Diemeyer

(a) RESIDENCE No. 26 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Diemeyer

6 DATE OF BIRTH (month, day, and year): Apr. 9 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
88	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mnfr. Hat Bonnets Frames

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country): Pungoteague Va

PARENTS

10 NAME OF FATHER: John E. Winder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mr. Charles M. Diemeyer

(Address): 26 W. Lexington St.

15 Filed APR 22 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from pr. cancer from Since abt 1926.

that I last saw her alive on April 20, 1927

and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Agr -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. K. Connell, M. D.

4-22-1927 (Address) 117 W. Lanvale St -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Apr 23 27

20 UNDERTAKER: Wm Tuckerbond

ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21492

CERTIFICATE OF DEATH.

E 21492

REGISTERED NO.

1-PLACE OF DEATH Mt H Mercy Hospital

CITY OF BALTIMORE: (No. ... St. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Helen M. Wix

(a) RESIDENCE NO. Pks Heights Ave cor Taney Road ST., WARD

(Usual place of abode) (If non-resident: give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Wix

6 DATE OF BIRTH (month, day, and year) Sept 10 1876

7 AGE — Years 50 | Months 7 | Days 11 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER C. W. Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Mattison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr John W. Wix (Address) Park Heights Ave

15 Filed APR 22 1927 19 C. HAMPTON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/20 27, 19 ..., to 4/21/27, 19 27 that I last saw h[illegible] alive on 4/21/27, 19 27 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/21/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Apl. 25 19 27

20 UNDERTAKER Wm J. Pickner & Son — ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21493

CERTIFICATE OF DEATH.

113 E 21493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 ~~Hanbert~~ St. 24-35 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jones

(a) RESIDENCE NO. 1407 ~~Hanbert~~ ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 27, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		7	24	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Patrick Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Dookins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs Sophia Dookyns
(Address) 1407 Hanbert St.

15 Filed APR 22 1927 19 C. HAMPSON JONES, M. D.
Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 21, 1927, that I last saw h[illegible] alive on April 21, 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Intoxication

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Infantile Convulsions

(duration) ..... yrs. ..... mos. 3 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E. S. Marr, M. D.

4. 21. 1927 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.Co.

DATE OF BURIAL April 23 1927

20 UNDERTAKER Chas. L. Stevens

ADDRESS 1501 Pennsylvania Ave

Spec.–7-17-26—A Co.—200 Bks.

E 21494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 21494

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 W. Lee St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Johnson

(a) RESIDENCE NO. 512 W. Lee St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roda Johnson

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER George W. Johnson Sr

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Phene Smith

13 BIRTHPLACE OF MOTHER (City or town) Md

(State or country)

14 Informant Roda Johnson

(Address) 512 W. Lee St.

Filed APR 22 1927, 19 C. HAMPTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to April 19, 1927

that I last saw h... alive on April 19, 1927

and that death occurred, on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

(Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

13 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation Symptoms

(Signed) C. Hampton Jones, M. D.

April 22 1927 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial April 22 27

20 UNDERTAKER Samuel F. Stanley ADDRESS 1128 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21495 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21495

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4612 Pall Mall ave St.) 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Littleton E. Price

(a) Residence No. 4612 Pall Mall ave St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Gertrude A. P

6-DATE OF BIRTH (month, day and year): Jan 24 63

7-AGE: 64 yrs. 2 mos. 27 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Lewis R E Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: E Littleton.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant) Gertrude A Price

(Address) 4612 Pall Mall ave

15- Filed ..... 192 ..... C. HAMDEN JONES, M. D. Registrar

APR 22 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 21 27.

17- I HEREBY CERTIFY, That I attended deceased from apl. 4 1927 to Apl. 21 1927 that I last saw him alive on apl. 21 1927 and that death occurred, on the date stated above, at 7:30A, m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Gall Stones

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. 7 mos 5 min.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Mettel M. D.

4/21 1927 (Address) 1403 W. North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: April 24 1927

20-UNDERTAKER: W. M. Courtenay

ADDRESS 2238 N Mont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21496 — REGISTERED NO. E 21496

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 West Virginia Avenue St., 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel T.Taylor

(a) RESIDENCE NO. 8 West Virginia Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M.Taylor

6 DATE OF BIRTH (month, day, and year) April 29,1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	11	19 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charlestown

(State or country) West Virginia

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Mary M. Taylor

(Address) 8 West Virginia Avenue

Filed APR 22 1927, 19 H. HANSEN JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927 — April 19,1927

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to April 19, 1927,

that I last saw him alive on April 19, 1927,

and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John S Rubert, M. D.

, 19 (Address) 4854 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Druid Ridge Cemetery — Date of Burial April 22 1927

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 217 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

202 E 21497

CERTIFICATE OF DEATH.

38 E 21497

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Washington

(a) RESIDENCE NO. 616 N Saratoga St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 29-1927

7 AGE: Years — Months 2 — Days 21 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Washington

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Helen Snell

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 22 1927 19 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 20-1927

17

I HEREBY CERTIFY, That I attended deceased from April 18th, 1927, to April 20th, 1927, that I last saw her alive on Apr. 20th, 1927, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. 2 mos. 22 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

Is Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray - Wassermann

(Signed) Howard Kemp, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: April 23 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 312 N. Schroeder St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21498

CERTIFICATE OF DEATH.

E 21498

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Carolina ST., 7-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hulas Stoke

(a) RESIDENCE NO. 915 N. Carolina ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-18-'26

7 AGE	Years	Months	Days 2	If LESS than 1 day, ...hrs. or....min.
	—	8	-20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Mert Stoke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Vera Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mert Stoke
(Address) 915 N. Carolina

15 Filed APR 22 1927 C. HAMILTON JONES, M. D. Registrar Per RJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20- 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-20-, 1927, to 4-20-, 1927, that I last saw h— alive on 4-20-, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Neil Haygood, M. D.

4-21-1927 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Bay. Va.

DATE OF BURIAL 4-23 1927

20 UNDERTAKER Jas. W. Skinner

ADDRESS 625 Broad st.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 21499

E 21499 1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. 103 West Mc Comas St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McDonald

(a) RESIDENCE NO. 103 West McComas Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James McDonald

6 DATE OF BIRTH (month, day, and year): unknown 1862

7 AGE: 65 Years Months Days — about 64

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: ? Hamilton

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: James McDonald

(Address): 103 West McComas

15 Filed ..... 19 ..... Registrar

APR 22 1927 C. HAS. R. JONES M. D.

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 16 19 27 to Apl 21 19 27

that I last saw h... alive on April 20 19 27

and that death occurred, on the date stated above, at 11.5 a m.

The CAUSE OF DEATH* was as follows:

Hepatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hamilton M. D.

4/21. 1927 (Address) 1 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: 4/23 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 501 E North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21500

E 21500

161-02

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

City of BALTIMORE: (No. _____ St., 9-46 Ward 1)

2-FULL NAME Baby Bell

(a) RESIDENCE NO. 1647 Bell St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 Color or Race White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20, 1927

7 AGE — Years: — Months: — Days: 1 — IF LESS than 1 day, hrs. or min.: 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NO

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER Willie Bell

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Maude Green

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md.

14 Informant Records

(Address) Johns Hopkins Hospital

Filed APR 22 1927 Per _____ HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1927, to 4-21, 1927

that I last saw h~~e~~ alive on 4-21, 1927

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____

(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? NO Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) J. K. Boerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Apr 22 1927

20 UNDERTAKER Lowe Cook ADDRESS 502 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK. ...tion should be carefully supplied. AGE should be stated EXACTLY ...CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21501

CERTIFICATE OF DEATH.

11-001

E 21501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 E. Henrietta ST., 22-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Carey

(a) RESIDENCE NO. 36 E. Henrietta ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mortona Carey

6 DATE OF BIRTH (month, day, and year): Aug 18 1887.

7 AGE — Years: 39 Months: 8 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Charles J. Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mary Carey

(Address): 36 E. Henrietta

15 Filed APR 22 1927 C. HAMILTON JONES, M. D. Registrar

by R/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19th 1927 to April 20th 1927

that I last saw him alive on April 20th 1927

and that death occurred, on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examinations

(Signed) Thomas H. Hamilton M.D.

4/22, 1927 (Address) 1024 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Country — DATE OF BURIAL: April 23 1927

20 UNDERTAKER: F. A. Sweares & Son — ADDRESS: 703 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

E 21502

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH East Brooklyn REGISTERED NO. 2677

CITY OF BALTIMORE: (No.) 55 - 3rd Ave. (ST., ROAD, OR WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hasse

(a) RESIDENCE NO. 55 - 3rd Ave. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	W	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) July 24-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer Infant

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Hasse.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Konieczna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm Hasse (Father)
(Address) 55 Third Ave. E. Roslyn.

15 Filed C. HAMPSON JONES, M. D. Registrar
APR 22 1927 For ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 16 1927, to Apr. 21 1927, that I last saw h[illegible] alive on Apr. 20 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary) 6 ds.
(duration) yrs mos

CONTRIBUTORY (Secondary)
(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Wirth, M. D.

Apr. 22, 1927 (Address) 816 - Pennington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery A. A. Co. DATE OF BURIAL April 23 1927

20 UNDERTAKER Lilly + Zeiler ADDRESS 1093 Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21503

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 N. Collington Avenue (St.) 8-16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kuhlow

(a) RESIDENCE NO. 1800 N. Collington Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asmus Kuhlow

6 DATE OF BIRTH (month, day, and year) 7/19/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Thomas Witzgall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Goeller

(Address) 1800 N. Collington Avenue

15 Filed APR 22 1927 C. HAMPSON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18 1927 to April 21 1927 that I last saw her alive on April 20 1927 and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Leucemia + Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Albert C. Goeller M. D.

4/21 1927 (Address) 2025 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/ 25 1927

20 UNDERTAKER Albert L. Hiltz Jr. ADDRESS 1606 N. Chester

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

E 21504

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21504

161-001

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Exeter St Rescue Home 5-11 Exeter St. WARD) 5-8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Doris Mae Wise

(Residence in Baltimore: No. Exeter St Rescue Home St.: yrs. mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female | 4-COLOR OR RACE white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6-DATE OF BIRTH March 30th, 1927 (Month) (Day) (Year)

7-AGE 21 yrs. mos. 22 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore City

PARENTS

10-NAME OF FATHER Albert Anderson

11-BIRTHPLACE OF FATHER (State or country) Sabillasville Md

12-MAIDEN NAME OF MOTHER Edna Way Wise

13-BIRTHPLACE OF MOTHER (State or country) Sabillasville Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. C. HAMPSON JONES, M. D. REGISTRAR

APR 22 1927

P. 290

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April 21, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11, 1927. to. Apr 20 1927. that I saw her alive on April 20, 1927. and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) yrs. mos. ds

Contributory (SECONDARY) Convulsions

(Duration) yrs. mos. ds.

(Signed) Flora Pollack M. D.

April 21 1927 (Address) 1112 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 10 ds. In the State yrs. mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Johns Hopkins Hospital | DATE OF BURIAL .191

20-UNDERTAKER Commissioner of Health | ADDRESS

APR 22 1927

Spec.—1-10-21—M&T—1500 Blks.

E 21505 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21505

CERTIFICATE OF DEATH. 14-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome C. O'Donovan

(a) RESIDENCE NO. 3617 Falls Road ST., WARD

(Usual place of abode) Woodberry, Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine O'Donovan

6 DATE OF BIRTH (month, day, and year) ? 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael O'Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eleanor Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Josephine O'Donovan. (Address) 3617 Falls Road

15 Filed APR 22 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-14- , 1927, to 4-14 , 1927, that I last saw him alive on 4-14 , 1927, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. , mos 5 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Work or Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Jno A. O'Donovan M. D.

, 19 (Address) 1 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 4/23, 1927

20 UNDERTAKER Henry H. Mears & Son ADDRESS 805 N. Calvert

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21506

CERTIFICATE OF DEATH.

31 E 21506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 930 N. Wolfe St., 7-13 Ward)

2-FULL NAME Charles F. Woollen

(a) RESIDENCE NO. 930 N. Wolfe St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Mar 6/1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furnisher do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Benisch & Co

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Woollen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Kate Farquaharson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant William Woollen

(Address) 930 N. Wolfe St

15 C. HAMPSON JONES, M. D.

Registrar

Per

APR 22 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Fibrosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Woollen M. D.
(Coroner)

4/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial 4/23 1927

20 UNDERTAKER William Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

21507 HEALTH DEPARTMENT—CITY OF BALTIMORE 21507

CERTIFICATE OF DEATH.

REGISTERED NO. 127

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. E. Taylor Ave. nr. Baker St. Ave., Parkville. WARD) 27-43

2-FULL NAME Marie K. Hofmann.

(a) RESIDENCE NO. E. Taylor Ave. ST., Parkville WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Adam G. Hofmann

6 DATE OF BIRTH (month, day, and year): Jan. 17th, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bayern Germany

PARENTS

10 NAME OF FATHER: Frederick Hugel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Justine Ordnung

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Adam G. Hofmann
(Address) E. Taylor Ave., Parkville, Md.

15 Filed APR 22 1927, 19 C. HARRY JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20th, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1927, to April 20, 1927, that I last saw her alive on April 20, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) A. Heller Hemming M. D.

4/24, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Apr. 23, 1927.

20 UNDERTAKER: Frederick Lessahn & Son

ADDRESS: Fullerton

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21508

CERTIFICATE OF DEATH.

90

E 21508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 W. Mulberry St. 18-26 Ward)

2-FULL NAME Elizabeth Metzger

(a) RESIDENCE NO. 928 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gottlieb Metzger

6 DATE OF BIRTH (month, day, and year): Jan 31, 1848

7 AGE: Years 79 | Months 2 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: F. W. Scharoun

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Geo D Atherton

(Address) 1103 W Franklin

15 Filed ..... 19..... JOHN JONES, M. D. Registrar

APR 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1927, to Apl 21, 1927, that I last saw h..... alive on Apl 21, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Organic disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

Signed: 4/21/27 J. Howard, M. D.

(Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial apr 23, 1927

20 UNDERTAKER: Mr. Mrs. John W. Teufel & Son ADDRESS 801 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21509

CERTIFICATE OF DEATH

E 21509

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 Faun St. 13-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Oriente

(a) RESIDENCE NO. 1010 Faun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. If of foreign birth 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cathrine Oriente

6 DATE OF BIRTH (month, day, and year) March 17 1865

7 AGE 73 Years — 1 Months — 4 Days IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS -

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Cathrine Oriente

(Address) 1010 Faun

15 Filed APR 22 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1927, to April 21, 1927, that I last saw him alive on April 21, 1927, and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Joseph L. Holmes M. D.

April 22, 1927 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Rosary — Date of Burial April 23 1927

20 UNDERTAKER Wendell Appel & Son — ADDRESS 375 Mn

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21510 — CERTIFICATE OF DEATH. — E 21510

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Foard

(a) RESIDENCE NO. 3 Elizabeth Ave, Bannon Ridge Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 1 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	~~single~~ white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Herbert Foard

6 DATE OF BIRTH (month, day, and year) Feb 2/1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles A. Hill

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ida A. Sapp

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto., Md.

14 Informant Wm. Herbert Foard

(Address) Bannon Ridge Md.

15 Filed _____ 19__ H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia following Streptococcic sore throat

(duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) _____ yrs. _____ mos. 2 ds.

(Signed) J. H. Polan M. D.

(Coroner)

4/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bowden Park Co. Date of Burial Apr 23 1927

20 UNDERTAKER Kendall Peppard ADDRESS 87 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 2 1927 C. HANSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21511

CERTIFICATE OF DEATH.

E 21511

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 22-30 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wojcyscikia

(a) RESIDENCE NO. 645 Dawn St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dont Know

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

PR 27 1927 By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to April 20, 1927, that I last saw h.. alive on April 19, 1927, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Hypertension

Residual left Hemiplegia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? Gen. & Labratory

(Signed) R. Hoopu Smith M.D.

April 27 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial April 23/1927

20 UNDERTAKER Daniel Eaton ADDRESS 640 Dawn St

P.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 21512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 21512

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 614 Collett Av. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Stevenson Boyer

(a) RESIDENCE NO. 614 Collett Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE — Years: 35 — Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: George Stevenson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Barbara Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Leo Stevenson

(Address): 613 Carlton ave

15 Filed ....., 19 .....

APR 22 1927 — Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 20, 1927, that I last saw h[er] alive on April 20, 1927, and that death occurred, on the date stated above, at 4:05 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital

(Signed) C. H. Jones M. D.

, 19 (Address) 2329 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: April 24/27

20 UNDERTAKER: Dennis Easton — ADDRESS: Pine

Spec.—12-9-25—A Co.—200 Bks.

E 21513

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21513

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 1420 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Ford

(a) RESIDENCE NO. 1400 Argyle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Ford

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed [illegible] 19 [illegible] Registrar

APR 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 21, 1927,

that I last saw him alive on April 20, 1927,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy Insufficiency

Generalized anasarca

(duration) yrs. ? mos. ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? general & laboratory

(Signed) J. Hooper Smith, M. D.

April 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Date of Burial April 23/27

20 UNDERTAKER Samuel Easton ADDRESS 916 Eager

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21514

CERTIFICATE OF DEATH.

E 21514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1019 Vincent St. 16-22 Ward)

2-FULL NAME Florence Spriggs

(a) RESIDENCE NO. 1019 Vincent St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richmond.

6 DATE OF BIRTH (month, day, and year): about 1899

7 AGE: Years 28 Months Days

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: General

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Rosie Mabie

(Address): 705 N. Mount St.

15 Filed ..... 19 ..... Registrar

APR 22 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquest)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquest) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy, M. D.

(Coroner)

April 24 19 27 (Address) 2812 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: April 23 1927

20 UNDERTAKER: Lewis E. Eaton ADDRESS: Penn. 946

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21515

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605 Llewlyn St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Berge

(a) Residence No. 1605 Llewlyn Ave St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Fredrick Berge

6-DATE OF BIRTH (month, day and year): Sept 1. 1887.

7-AGE: 39 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Grocery Work
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Penn. Down Com.

PARENTS.

10-NAME OF FATHER: John Della

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Virginia Chenga

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington D C

14- (Informant) Fred Berge

(Address) 1605 Llewlyn ave

15- Filed APR 22 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-20-27

17- I HEREBY CERTIFY, That I attended deceased from 4-1- 1927 to 4/20 1927, that I last saw h[illegible] alive on 4-20 1927 and that death occurred, on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Muller M. D.

4/21 1927 (Address) 1 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] St Vincents Cypress DATE OF BURIAL: April 23 1927.

20-UNDERTAKER: Wendell J. Hyspiel ADDRESS: 300 S Edwards

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21516

CERTIFICATE OF DEATH.

90E 21516

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 E Fort ave. ~~or 24~~ (Ward) 33

REGISTERED NO. C

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Mrs) Marie Bray

(Residence in Baltimore: No. 800 Fort ave St.: 6 yrs., — mos. — da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, June (Month) 16 (Day), 1838 (Year)

7-AGE, 88 yrs. 10 mos. 4 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), 37

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Bray

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Walter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. N. Lisco, M.D.

(Address) 1315 N Charles St.

15-

Filed ..... 19..... C. HERSON JONES, M.D.

Registrar.

By .....

MAR 22 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 21 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ——— 1915, to Apr 21 1927, that I saw her alive on Apr 20 1927, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ? yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) H. N. Lisco M. D.

Apr 21, 1927 (Address) 1315 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel — DATE OF BURIAL, April 25 1927.

20-UNDERTAKER, Wendell S. Hippel — ADDRESS, 300 E Eden St

Spec.—7-17-26—A Co.—200 Bks.

E 21517

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21517

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 73 Wickham Road (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Bauer

(a) RESIDENCE NO. 73 Wickham Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Bauer

6 DATE OF BIRTH (month, day, and year): May 5 66

7 AGE: Years 60 Months 11 Days 16 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Reidel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Amand

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: John J. Bauer

(Address): 73 Wickham Rd.

15 Filed: APR 23 1927

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Apr 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1926 to Apr 21, 1927 that I last saw h[illegible] alive on Apr 21, 1927 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Hypertension Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted: Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

4/22 1927 (Address) 27 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

Date of Burial: April 23 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 1422 Light St

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 E 21518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 158 S. Smallwood St. 20-69 Ward)

2-FULL NAME John J. Bowen.

(a) RESIDENCE NO. 15 S. Smallwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 30

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER William H. Bowen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kent Co., Md.

12 MAIDEN NAME OF MOTHER Margaret A. Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pittsburgh Pa.

14 Informant Miss Emma Bowen (Sister)

(Address) 158 S. Smallwood St.

15 C. HAMILTON JONES, M. D.

APR 23 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained at said Inquest, and from

.....find that said deceased came to ... death by

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain (cause)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shot Self in head At once

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Apr 24 1927 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cem.	April 23 1927
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light St

R 23 1927

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21519

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21519

CERTIFICATE OF DEATH.

X 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

2-FULL NAME Elvine Levitt Staum

(a) RESIDENCE NO. Linden Ave Pa St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed. married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 27, 1866

7 AGE: Years 61 | Months 2 | Days 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer) #6

(c) Name of employer

9 BIRTHPLACE (city or town) Md—

(State or country)

PARENTS

10 NAME OF FATHER Jorge Staum

11 BIRTHPLACE OF FATHER (city or town) Md—

(State or country)

12 MAIDEN NAME OF MOTHER Harriet Strut

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 C. [illegible] JONES, M. D.

Registrar

APR 23 1927

Per Reb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to April 20, 1927, that I last saw him alive on April 20, 1927, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis 5 yrs (?)

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency. Femoral thrombosis (duration) yrs. mos. 16 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Louis Evelyn Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

Date of Burial Apr 23 1927

20 UNDERTAKER Robt. J. Turner

ADDRESS 1402 E. Baltimore

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21520

CERTIFICATE OF DEATH

12 9 E 21520

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1013 N Fulton ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Brown

(a) RESIDENCE NO. 1013 N Fulton ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year): Sept 10 1856

7 AGE: 70 Years 7 Months 11 Days — IF LESS than 1 day ..... hrs. or ..... min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jas K Kneeland

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: annie bare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Florence R Brown

(Address): 1013 N Fulton ave

15 Filed APR 23 1927 — C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 - 1927 at 4 P M

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to April 21, 1927, that I last saw h[illegible] alive on April 21, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis and Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward T. Guest, M. D.

Apr 22, 1927 (Address) 1717 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — Date of Burial: Apr 25 1927

20 UNDERTAKER: Robert Brookerson — ADDRESS: Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-27—M&T—500 Bks.

E 21521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 E 21521

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oakland ST., 10 WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs Blanche Alexander

(a) RESIDENCE No. 1224 Oakland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 ~~Single~~ ~~Married~~, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced: HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE: Years 34. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) maryland.

PARENTS

10 NAME OF FATHER J. H. Frosh

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) maryland.

12 MAIDEN NAME OF MOTHER Laura Davis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) maryland

14 Informant Mrs Sadie Lindermon (Address) 112 S Calhoun Street

15 Filed APR 23 1927, 19 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/18/27, 1927, to 4/22/27, 1927 that I last saw h alive on 4/22/27, 1927 and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pelvic inflammatory disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Post operative shock

Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 4/19/27

Was there an autopsy? no

What test confirmed diagnosis? clinical & operation

(Signed) H. A. McCann, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Allsaints Rustertown — DATE OF BURIAL 4-26-1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Calhoun Martin-st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21522 — 74-81 — E 21522

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 924 Warner ST., 23-31 (WARD)

2-FULL NAME Della Robinson Gross

(a) RESIDENCE NO. 924 Warner ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Gross

6 DATE OF BIRTH (month, day, and year) — 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Demaury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary L. Lynch
(Address) 2143 Druid Hill Ave

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar
By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 19, 1927, that I last saw her alive on April 19, 1927, and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Calvert, M. D.

, 19 (Address) 924 Warner St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 4/23 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1627 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21523

CERTIFICATE OF DEATH.

51 E 21523

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 23-33 (Ward)

2-FULL NAME Louis Rapp

(a) RESIDENCE NO. 1107 Patapsco St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed or divorced, HUSBAND of (or) WIFE of: Agnes Schalzky

6 DATE OF BIRTH (month, day and year): Feb 9 1898

7 AGE: Years 29 Months 2 Days 11 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto driver

(b) General nature of industry, business, or establishment in which employed (or employer): 823

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jno Rhodi

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Julia Meyers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto

14 Informant: Mrs Agnes Rapp

(Address): 1103 Patapsco Ave

Filed R 2 3 1927 C. HAMPSON JONES, M. D. Registrar

Per AKS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis Rheumatic

Duration (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Kelly M. D.

(Coroner)

April 22, 1927 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Date of Burial: April 25 1927

20 UNDERTAKER: F. A. Kleman & Son. ADDRESS: 703 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21524

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21524

CERTIFICATE OF DEATH.

65-50

1-PLACE OF DEATH

City of BALTIMORE: (No. 510 N. Carey St St. 19-7a Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Genevieve Snowden

(a) Residence No. 510 N. Carey St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 5-15-15

7-AGE, 11 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Willis Snowden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Bessie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Jennie Snowden

(Address) 510 N. Carey St.

15- Filed..... 19.... C. HAMPSON JONES, M. D. Registrar.

APR 23 1927 per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-22-27

17- I HEREBY CERTIFY, That I attended deceased from 4-10-, 1927 to 4-22, 1927, that I last saw h[illegible] alive on 4-22, 1927, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) H. Marco Williams M. D.

4-23, 1927 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn

DATE OF BURIAL, Apr 25 1927

20-UNDERTAKER, Hamilton Undertaking Co

ADDRESS 1400 Madison Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 21525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154-002

154 E 21525

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2703 Bunard St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Arthur Proctor

(a) RESIDENCE NO. 2703 Bunard St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 20, 1926.

7 AGE — Years: 5 Months: Days: 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none. old

(b) General natnre of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: Norman Proctor

11 BIRTHPLACE OF FATHER (City or town): md.

(State or conntry)

12 MAIDEN NAME OF MOTHER: Mary E. Hall.

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Norman Proctor

(Address): 2703 Bunard St

15 Filed APR 23 1927 C. HARPER JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927. to April 22, 1927.

that I last saw h[illegible] alive on April 21, 1927

and that death occurred, on the data stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows: Myocarditis

Certified by Coroner J. Thomsen

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation preceede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and

(Signed) [illegible] M. D.

, 19 (Address) 330 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden — Date of Burial: April 23, 1927

20 UNDERTAKER: Chenowethson — ADDRESS: 3615 Greenmount Ave

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21526

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21526

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 104 Franklin (St.) Rutland (WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo J Seifert

(a) RESIDENCE NO. 104 E Franklin Ave (St.) Rutland WARD 27 ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ann

6 DATE OF BIRTH (month, day, and year): Sept 8 1854

7 AGE — Years: 72 — Months: 7 — Days: 13 — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gardenville Balt Co. Md

PARENTS

10 NAME OF FATHER: Christ Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Hirschmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Seifert (Address) 104 E Franklin Ave. Rutland

15 MAR 23 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1927. to April 21. 1927.

that I last saw h alive on " " 1927.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D Cone, M. D.

19 (Address) Cone & Cantlon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: April 25 1927

20 UNDERTAKER: Frederick Lassahn Sons — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21527

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21527

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1927 Augusta St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Harris

(a) Residence No. 1927 Augusta St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura Harris

6-DATE OF BIRTH (month, day and year) Centennial 1871

7-AGE 56 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Various Cos

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS

10-NAME OF FATHER John Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Laura Harris

(Address) 1927 Augusta St

15- Filed APR 22 1927 GEO. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 20, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927 to Apr. 19, 1927.

That I last saw him alive on Apr 19 1927.

And that death occurred, on the date stated above, at 9 A.M. m.

THE CAUSE OF DEATH* was as follows: Organic Heart Disease.

Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evs.

(Signed) C. Garland Littlepage M. D.

Apr 22 1927 (Address) 1534 - 20 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — DATE OF BURIAL Apr. 23 1927

20-UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Ashland Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 21 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21528

CERTIFICATE OF DEATH.

90 E 21528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospitals (Ward) 4-27

2-FULL NAME Clarence Sibold.

(a) RESIDENCE No. 1316 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845 ?

7 AGE — Years: 82 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nail

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Christopher Sibold

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Hospital Record

(Address)

15 Filed ..... 19 ..... AMON JONES, M. D. Registrar

APR 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 27 19

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927 to April 20, 1927

that I last saw h.. alive on April 20, 1927

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Generalized Osteosclerosis, Chronic Myocarditis, Chronic Nephritis

(duration) Unknown

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

Date of Burial: April 19 27

20 UNDERTAKER: Everly Embalming Service

ADDRESS: 2 Clifton Boulevard

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 21529

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21529

60-00

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No. 33 d, Calvert St. 11-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn S. France

(a) RESIDENCE NO. 15 W. Mount Vernon Pl. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. J. I. France

6 DATE OF BIRTH (month, day, and year): Aug 3, 1855

7 AGE Years 71 Months 8 Days 19

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Mr. H. C. Merritt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Miss H. Abrahams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant: Jos. Jules I. France

(Address) Mount Vernon Pl. City

15 Filed: CARLSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 22, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 22, 1927, that I last saw h.r alive on April 22, 1927, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of April 20, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond F. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopewell Cem Post to Loposit Md April 25 1927

Date of Burial

20 UNDERTAKER: Henry H. Jenkins Sons Co

ADDRESS: Cor Fallsway & Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 2 3 1927

Dr Gabell. 2413 St Paul St

Spec.—7-17-26—A Co.—200 Bks.

E 21530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21530

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 E 24th St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J Ath. Lee

(a) RESIDENCE NO. 112 E 24th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abram C Ath. Lee

6 DATE OF BIRTH (month, day, and year): June 25, 1845

7 AGE: Years 81 Months 9 Days 26 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Carrol Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Cromwell

11 BIRTHPLACE OF FATHER (City or town): Frederick

(State or country): Md

12 MAIDEN NAME OF MOTHER: Catharine Cromwell

13 BIRTHPLACE OF MOTHER (city or town): Frederick

(State or country): Md

14 Informant: Abram C Ath. Lee

(Address): 112 E 24th St

15 Date: 4-23-1927 16 [illegible] Registrar: ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to April 21, 1927, that I last saw her alive on April 21, 1927, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Gabell M. D.

19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — Date of Burial: Apr 23 1927

20 UNDERTAKER: Wilkom Cook — ADDRESS: 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21531

HEALTH DEPARTMENT—CITY OF BALTIMORE

Mr Donovan
5 E Read St

CERTIFICATE OF DEATH.

89 E 21531

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 717 E 21st St. 9-46 WARD)

2-FULL NAME Annie Farrell

(a) RESIDENCE NO. 717 E 21st St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie S Farrell

6 DATE OF BIRTH (month, day, and year) Jan 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER McKenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie S. Farrell
(Address) 717 E 21st St

15 Filed APR 3 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 21, 1927,

that I last saw h alive on April 20 1927,

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Art. Sclerosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas C. Donovan, M. D.

19 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Apr 25 1927

20 UNDERTAKER Wm Cook Son & Gorsuch — ADDRESS

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S duplicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21532

CERTIFICATE OF DEATH.

31 E 21532

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Buckheit

(a) RESIDENCE NO. 2034 Edmondsonave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) (Mar 1, 1855) 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Indiana

PARENTS

10 NAME OF FATHER Martindale, David

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 22, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927 to April 22, 1927, 19....,

that I last saw her alive on April 22, 1927 19....,

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

4-22-27 (Signed) W. E. Gatterus, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial Apr 25 1927

20 UNDERTAKER W. W. Cook ADDRESS 502 E Baltimore

APR 23 1927

WHITE PLEASE, AND EXPLANATORY INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Julia 1123 Taylor Ave 2d

E 21533

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21533

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 612 Pulaski Ave (ST.) 16-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Rinehart

(a) RESIDENCE No. 612 Pulaski Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Rinehart

6 DATE OF BIRTH (month, day, and year) March 16 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	1	5	4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Galt Md

PARENTS

10 NAME OF FATHER John McGrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Emily Cuss

(Address) 612 Pulaski Ave B.

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 15, 1927, that I last saw her alive on April 15, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy with Chronic Nephritis

(duration) 1 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Symptoms + Signs

(Signed) Jno L Carter, M. D.

April 1927 (Address) 1123 Eutaw Place (corner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL April 25 1927

20 UNDERTAKER Wilhelm Cook — ADDRESS 502 E Balt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21534

CERTIFICATE OF DEATH.

90 E 21534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1506½ N. Gay St., 8-17 Ward)

2-FULL NAME James P. Brewer

(a) RESIDENCE NO 1506½ N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male 4 Color or Race: White 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of WIFE of: Martha Brewer

6 DATE OF BIRTH (month, day, and year): Jan 29/79

7 AGE: Years 47 Months 3 Days 8 IF LESS than 1 day.....hrs. or.....min. 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): 604

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wilson N. C.

PARENTS

10 NAME OF FATHER: Sam'l A. Brewer

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Sarah A.

13 BIRTHPLACE OF MOTHER (City or town) (State or country): N. C.

14 Informant: Martha Brewer

(Address) 1506½ N. Gay St.

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 21/27

17 I HEREBY CERTIFY, That I attended deceased from April 20 27, to April 21, 19..., that I last saw h... alive on April 21, 19..., and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Asthma 24 hr

(duration) yrs. mos. ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed) Wm. Brunt Bruce M. D.

1927 (Address) 1407 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Date of Burial 4/25 1927

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 23 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21535

CERTIFICATE OF DEATH.

X 74-001 E 21535

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 N. Bals. Ward 20-26)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr James L. Truax

(a) RESIDENCE NO. Eastern Ave near North Pt Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Carrie Truax

6 DATE OF BIRTH (month, day and year): Oct 29 1867

7 AGE: Years 54 Months 5 Days 22

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 054

(c) Name of employer: —

9 BIRTHPLACE (city or town) Del, (State or country)

PARENTS

10 NAME OF FATHER Isaac Truax

11 BIRTHPLACE OF FATHER (city or town) Del (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Del (State or country)

14 Informant Carrie Truax

Address Eastern Ave, Near North Pt Road

Filed APR 23 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) at once yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Apr 22nd 1927 (Signed) Wm. B. Horton M. D. (Coroner)

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.) Hemorrhage Brain

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: 4/25 1927

20 UNDERTAKER: Philip Herring — ADDRESS 306 Orleans St

If the stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21536

CERTIFICATE OF DEATH.

31 ✓ E 21536

1-PLACE OF DEATH

City of BALTIMORE: (No. 2016 Portugal St. 24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Louis Mueller

(a) RESIDENCE NO. 2016 Portugal St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida May Mueller

6 DATE OF BIRTH (month, day, and year) Dec. 27th/78

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
48	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Molder

(b) General nature of indnstry, business, or establishment in which employed (or employer) Ø+T

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Mueller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schoenhals

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Ida May Mueller

(Address) 2016 Portugal St.

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 1927, to Apr 19, 1927 that I last saw alive on Apr 18, 1927, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Laryn T. B.

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) A. Lawson

(duration) yrs. mos. ds.

18 Where was disease contracted — —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? Dr. Thy Evans

What test confirmed diagnosis? P. C. Wades

(Signed) , M. D.

, 19 (Address) 143 W. Lan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 4/23 1927

20 UNDERTAKER Philip Stenzig ADDRESS 2016 Orleans St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21537

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals St. (E.B.) Ward)

2-FULL NAME Barbara Schmidt

(a) RESIDENCE NO. Bay View St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Schmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Maggie Reed

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

Filed C. HAMILTON JONES, M. D.

Registrar

R 23 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1917 to April 21, 1927, that I last saw her alive on April 21, 1927, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous osteitis of spine (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary thrombosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. E. Gallus, M. D.

4-21-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Apr 25 1927

20 UNDERTAKER Ellis Leo & Sons ADDRESS E Monument

tion should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21538

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21538

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1139 N. Gilmor ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel E. Johnson

(a) RESIDENCE NO. 1139 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh[illegible]tate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel E. Johnson

6 DATE OF BIRTH (month, day, and year): Nov. 18, 1871

7 AGE: Years 55 Months 5 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co. Md.

PARENTS

10 NAME OF FATHER: Alfred Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md

12 MAIDEN NAME OF MOTHER: Sarah E. Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant: Alfred T. Berry

(Address) 1139 N. Gilmor St.

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21- 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-25- , 1927 , to 4-21- , 1927 ,

that I last saw her alive on 4-19- , 1927 ,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease & Fibrosis of Lungs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George Chase M. D.

, 19 (Address) 816 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: April 24-27

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1307 Prestman St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21539

CERTIFICATE OF DEATH.

188-083 E 21539

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Charles Harmon Demuth

(a) RESIDENCE NO. 1032-W-Franklin-St. St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 4 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 62 yrs. 6 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Depser Demuth

6 DATE OF BIRTH (month, day, and year) October-16-1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Barbering

(c) Name of employer (self)

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick H.Demuth

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Prince

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Germany

14 Informant Mr.C.Raymond Demuth (son)

(Address) 1032-W-Franklin-St.,City.

15 Filed ..... 19 ..... Registrar

APR 23 1927

Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

few minutes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Corner)

April 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 0 yrs., 0 mos., 0 ds. In the State 62 yrs., 6 mos., 4 ds.

Where was disease contracted, if not at place of death? Edmondson Av-Monroe St.

Former or usual residence 1032-W-Franklin-St.,City.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Apr-23-27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 103 W.NORTH AVE.

(Cause should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement very important. See instructions on back of certificate.)

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21540

CERTIFICATE OF DEATH

101-801 E 21540

REGISTERED NO. 15-61

1-PLACE OF DEATH

City of BALTIMORE: (No. 3305-Windsor Mill Road St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gott Andrews

(a) RESIDENCE NO. 3305-Windsor Mill Road St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 62 yrs. 7 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Beitman Andrews

6 DATE OF BIRTH (month, day, and year) September-22-1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	62	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman for the 066

(b) General nature of industry, business, or establishment in which employed (or employer) Armstrong Cator Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Cockeysville

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Clay Andrews

11 BIRTHPLACE OF FATHER (City or town) York

(State or country) Penna

12 MAIDEN NAME OF MOTHER Alice Ann Gott

13 BIRTHPLACE OF MOTHER (city or town) Long Green

(State or country) Maryland

14 Informant Miss Ada M. Andrews (sister)

(Address) 3305 Windsor Mill Road, City.

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 22 1927

17 I HEREBY CERTIFY, That I attended deceased from apr 1, 1927, to apr 22, 1927.

that I last saw him alive on apr 21, 1927.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Pobe

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) ~~Edema~~ myocarditis

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S Niblett, M. D.

4/22, 1927 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Apr 11-25-1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21541

CERTIFICATE OF DEATH

101-001

E 21541

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital Ward) 68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Franklin

(a) RESIDENCE NO. 503 Columbus St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Franklin

6 DATE OF BIRTH (month, day, and year) May 1 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town)

(State or country) Unk

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unk

14 Informant Wm Franklin

(Address) 503 Columbus St

15 APR 23 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 19, 1927.

that I last saw h[illegible]ive on April 17, 1927.

and that death occurred, on the date stated above, at 2.05 p m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia Bilateral

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) [illegible], M. D.

April 19 1927 (Address) 505 Columbus St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — Date of Burial April 23 1927

20 UNDERTAKER Edward Bryan — ADDRESS 651 Orleans St

U. S. BUREAU OF THE CENSUS, WITH CO-OPERATING STATES—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21542

31 E 21542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2517 Jefferson ST., 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Brennan

(a) RESIDENCE No. 2517 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Brennan

6 DATE OF BIRTH (month, day and year) March 18 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	65	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fire Man

(b) General nature of Industry, business, or establishment in which employed (or employer) 032

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Brennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary Brennan 2517 Jefferson st

15 Filed APR 23 1927 C. HARRISON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1 1927 to 4-21 1927

that I last saw h alive on 4-20 1927

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Dil Edema

(duration) yrs. mos. da.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Fred Smith M. D.

(Address) 100 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL April 25 27

20 UNDERTAKER Wm. G. Schaffer — ADDRESS 1816 Monument

R 23 1927

M. C. WHITE ENGR. MFG. CO., BALTIMORE, MD. THIS BLANK CONFORMS TO THE STANDARD PERMANENT RECORD. Type-written, with carbon paper, is preferred. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21543 E 21543

CERTIFICATE OF DEATH.

70-69 7H-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2561 W. Fayette St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Kerchner

(a) RESIDENCE No. 2561 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob B. Kerchner

6 DATE OF BIRTH (month, day, and year) March 26, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jessie Crowl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis Scherf

(Address) 2561 W. Fayette St

15 Filed APR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per CRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927 to April 20, 1927 that I last saw her alive on April 20, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5 Yrs

Cerebral Hemorrhage 2 Yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ellen O. Cruikshank M. D.

4/22/27 (Address) 24 W Fullton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminister Md.

DATE OF BURIAL 4/24 1927

20 UNDERTAKER Harry H Weitzle

ADDRESS 1501 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Physician's signature to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21544

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21544

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. University Hospital. St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Dillon.

(a) RESIDENCE NO. 809 Hanover St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	Aoout 54	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) Do not know.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. S.D.

(Address)

15 Filed, 19 Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably,

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto A Reinhardt M. D.

(Coroner)

4/22 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial April 23 1927

20 UNDERTAKER Harry H Hubbs ADDRESS 1531 N Fulton Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R2 1927 C. H. S. A. S. Registrar

For

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21545

CERTIFICATE OF DEATH.

90 E 21545

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 W. Conway St.; 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma F. Mason

(Residence in Baltimore: No. 406 W. Conway St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1867 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Mercer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Keys

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo Hooper

(Address) 406 W Conway St

15- C. HAMPSON JONES, M. D.

Dec 23 1927 ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1927 to March 21 1927 that I saw h[illegible] alive on March 20 1927 and that death occurred, on the date stated above, at 3P, m.

The CAUSE OF DEATH* was as follows: Cardiac Dilatation & Exhaustion

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) C. H. Jones M. D.

March 23, 1927 (Address) 712 S Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 4-2-27

20-UNDERTAKER J Leon Hall ADDRESS 406 W Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

23 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21546

CERTIFICATE OF DEATH

74-001 E 21546

1-PLACE OF DEATH

REGISTERED NO. 15-58

City of BALTIMORE: (No. 2702 Ulman Ave. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gardner

(a) RESIDENCE NO. 2702 Ulman Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. if of foreign birth 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Gardner

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1849

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs. or ...min..
	77	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER — Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Milton Gardner

(Address) 2702 Ulman Ave

15 Filed ..., 19..

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. ..., 19 25 to April 23, 1927.

that I last saw h[illegible] alive on April 22, 1927.

and that death occurred, on the data stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted Baltimore

if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] Jacob Cohen, M. D.

4/23, 1927 (Address) 223 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. Date of Burial 4/25/ 1927

20 UNDERTAKER Harry Sonnheim ADDRESS 118-20 W. Mt. Royal Ave.

PR 4 1927

Instructions: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21547 (×) E 21547

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPIT St. 16-47 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Sidney Fox

(a) RESIDENCE NO. 719 Edgewood Ave St. Ward Trenton - N. J.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept —

7 AGE: Years 11 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Jersey

(State or country)

PARENTS

10 NAME OF FATHER Fred Fox

11 BIRTHPLACE OF FATHER (city or town) N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER Nellie Lewis

13 BIRTHPLACE OF MOTHER (city or town) N. Y.

(State or country)

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 24 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to April 23, 1927, that I last saw h[illegible] alive on April 23, 1927, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Glioma, Benign

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/16/27; 4/4/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George G. Finney, M. D.

4/23/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trenton N J — Date of Burial 4/23/27

20 UNDERTAKER Joseph Stevens — ADDRESS 221 Bway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

E 21548

CERTIFICATE OF DEATH.

E 21548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 14-20 ST. (WARD)

2-FULL NAME Benjamin Schnierer

(a) RESIDENCE No. 503 Eutaw Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Beatrice Schnierer

6 DATE OF BIRTH (month, day, and year) Apr. 25, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Senior Medical Student

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER Louis Schnierer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Sarah Rosengarden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hosp. Records.

(Address)

15 Filed APR 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/4/27, 19, to 4/23/27, 19, that I last saw h/ alive on 4/23/27, 19, and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH* was as follows:

Acute Myelogenous Leukemia

Acute Vincent's Angina of mouth and throat

Leukemia (duration) one year yrs. mos ds.

Vincents Angina 10 days

CONTRIBUTORY (Secondary) Edema of Epiglottis Tracheal Stenosis

(duration) yrs. mos. ½ hour ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/23/27

For edema of the glottis

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) J. S. Winstead, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn, N.Y.

DATE OF BURIAL 4/24/1927

20 UNDERTAKER Burd Sonneborn

ADDRESS 1840 Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21549

CERTIFICATE OF DEATH.

E 21549

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oden Hardesty

(a) RESIDENCE NO. 1925 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Hardesty

6 DATE OF BIRTH (month, day, and year) June 21. 1872

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
54	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER James Hardesty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Tent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 24 1927, 19 H. M. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to April 21, 1927, that I last saw h.Nos. alive on April 21, 1927, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis, & hypertension, arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) hypocardia insufficiency

(duration) yrs. 4 mos. ds.

IS Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic examination

(Signed) Christopher Johnston, M. D.

4/21, 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Apr 25 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21550

100-001

CERTIFICATE OF DEATH

E 21550

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4203 Springdale Ave (Street) 28-14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Vincent Close

(a) RESIDENCE NO. 4203 Springdale Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie B. Close

6 DATE OF BIRTH (month, day, and year) October 27th 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flour Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) C. D. Kenny Co

(c) Name of employer C. D. Kenny Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H. Close

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha E. Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs Nellie B. Close

(Address) 4203 Springdale Ave

15 Filed APR 24 1927 H. A. 3 HAMILTON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14th 1927, to April 24th 1927, that I last saw h[illegible] alive on April 21st 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis, duration 10 days

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William Swesek M. D.

4 27 1927 (Address) 1700 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cem	Apr. 25th 1927
20 UNDERTAKER	ADDRESS
Jos. L. & J. B. Cook	1003 N. Eutaw St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21551

CERTIFICATE OF DEATH.

× 74001

E 21551

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2938 St. Paul St. 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Randolph Robinson

(a) RESIDENCE NO. "Severn" A.A.Co. Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 9th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: John Mercer Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: M. Champe Carnay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lynchburg Va

14 Informant: Richard Morton

(Address) 807 Equitable Bldg Balto

15 Filed APR 24 1927 CHARLTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 23. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1927, to April 23, 1927, that I last saw h[er] alive on April 22, 1927 and that death occurred, on the date stated above, at 12.42 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis —

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

in Dec 1926 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Atlantic City N.J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. Reinhard, M.D.

Apl 23 1927 (Address) 1327 Park Ave. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Apr 26 1927
20 UNDERTAKER	ADDRESS
J. W. Jenkins Son Co	Oakland Mt. Cullen

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21552

CERTIFICATE OF DEATH.

74-001

E 21552

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 526 N. Pulaski St. St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Pagano

(a) RESIDENCE NO. 526 N. Pulaski St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Pagano

6 DATE OF BIRTH (month, day) and year March 4th 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 645

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Pagano

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Elizabeth Pagano

(Address) 526 N. Pulaski St.

15 Filed APR 24 1927, 19 C. HAMILTON JONES, V. D.

Per R. C. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. T. Haverty M. D.

(Coroner)

April 22 19 27 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 4/25 1927

20 UNDERTAKER Chas. P. Evans & Son ADDRESS 113 W. Mt. Royal Ave

Bon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21553

CERTIFICATE OF DEATH.

18-003

E 21553

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Emmaus Ave St. 22-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maraty Butler

(a) RESIDENCE NO. 614 W Barre St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 20 1920

7 AGE: Years 6 Months 8 Days 1 IF LESS than 1 day.....hrs. or.....min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country)

PARENTS

10 NAME OF FATHER Clarence Butler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Lillie Fry Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant Lillie Butler

(Address) 614 W Barre St

15 Filed APR 24 1927 19 H. C. JONES, M. D. Registrar

By R. H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(If post, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Injuries Fracture of Skull by Truck 4/15/27

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracturing of Femur

(duration) yrs. mos. ds.

(Signed) Leonard J. Kelly M. D.

(Coroner)

19 27 (Address) 3325 Potter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

Date of Burial 4/24 1927

20 UNDERTAKER Leonard Hawley

ADDRESS 978 N Eutaw

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tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21554

CERTIFICATE OF DEATH.

44

REGISTERED NO. E 21554

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST. 3-5 WARD)

2-FULL NAME Michal Shemsu

(a) RESIDENCE No. 42 Abermarle St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Circa 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Esther Sherman

(Address) 42 Abermarle St

15 Filed APR 24 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-18- , 1927, to 4-23 , 1927,

that I last saw him alive on 4-23 , 1927,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

C oedema of lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma stomach & metastasis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) J. Theron Hunter, M. D.

4/23 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henning Pen

DATE OF BURIAL 4/24 1927

20 UNDERTAKER H. Lurman & Co

ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21555

CERTIFICATE OF DEATH.

101-001 E 21555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 Arbutus av ST., Lakeland WARD 13)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian May Hughes.

(a) RESIDENCE NO. 445 Arbutus av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. M. Hughes.

6 DATE OF BIRTH (month, day, and year) Oct 12-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	31	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Julius Ackerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mr. Chas. Hughes. 445 Arbutus av.

15 Filed APR 24 1927 C. HAMPSON JONES, M.D. Registrar Per H.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 4.18, 1927, to 4.23, 1927, that I last saw h[illegible] alive on 4.23, 1927, and that death occurred, on the date stated above, at 9 P M

The CAUSE OF DEATH* was as follows:

Pleuro Pneumonia (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 4 mos. 4 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. J. Burlington, M. D.

4/25/1927 (Address) 102 E York av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem — DATE OF BURIAL 4/26 1927

20 UNDERTAKER L. Fen McCully — ADDRESS 306 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21556

CERTIFICATE OF DEATH.

E 21556

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 76-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Gloa

(a) RESIDENCE NO. 3245 Philadelphia Rd. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced (or) WIFE of Nicholas Gloa

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 27

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant [redacted] Records

15 Filed APR 24 1927 Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to April 22, 1927, that I last saw h.. alive on April 22, 1927, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

Myocardial hypertrophy & Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R. Hooper Lynch, M. D.

April 23 1927 (Address) [redacted] MORE CITY HOSPITALS

*State the Disease [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cem	Apr 25 1927

20 UNDERTAKER Gus C. Miller & Son ADDRESS 2334 Eastern Ave

You should be extremely careful. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21557 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21557

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 S 14th St. 26-37 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alex

(a) RESIDENCE No. 615 S 14th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec. 8 1908

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	4	14 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spanish Pt Va

PARENTS

10 NAME OF FATHER Geo. Alex

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rox Baumgartner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Geo Alex (Address) 615 S 14th St

15 Filed APR 24 1927 19 C. HARRISON JONES, M.D. Registrar RAK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/15, 1927, to 4/22 1927.

that I last saw her alive on 4/21 1927.

and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gouty Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rheumatism

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H S Judkins M.D.

4/22 1927 (Address) 3323 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	4/25 1927

20 UNDERTAKER J. J. Moran ADDRESS 3000 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A.C.—200 Bks.

E 21558

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

E 21558

CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md, 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Smith

(a) RESIDENCE NO. 804 N. Gilmor St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not stated

6 DATE OF BIRTH (month, day, and year): Mar. 5-1879

7 AGE — Years: 48 — Months: 1 — Days: 6 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Marco Washington

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Emeline Hunter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Virginia

14 Informant: Katie Lowenhurst Sister

(Address) 804 N. Gilmor St.

15 Filed 4 24 1927 H. RUSSELL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21 19 27

17

I HEREBY CERTIFY, That I attended deceased from 11-1- 1926 to 4-21 19 27

that I last saw h[illegible] alive on 4-20 19 27

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Cerebral Arterio Sclerosis & Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) H. W. Stevens 4/21/27

(Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: Apr 24 27

20 UNDERTAKER: Geo. M. Johnson — ADDRESS 1234 Eutaw St

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21559 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1170 Carroll St. 21-29 WARD) 91

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Teubner

(a) RESIDENCE NO. 1170 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Geo. H. Ludovey

(Address) 120 Carroll St JONES, M.

15 Filed APR 24 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to April 22, 1927, that I last saw h alive on April 21, 1927 and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

61

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J Whitridge Hoag, M. D.

Apr 23 1927 (Address) 719 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 4-25 1927

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21560

CERTIFICATE OF DEATH.

GO E 21560

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1406 Forest St. 3-4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Rutenskey

(a) RESIDENCE NO. 1406 Forest St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Rutenskey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer City

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Frank Rutenskey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary Collison

(Address) 1406 Forest St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) and that said deceased came to Em death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilation of Heart

(duration) 1 yrs. mos. ds.

(Signed) James M. Fenton, M. D.
(Coroner)

4/23 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St Stanalaus	April 27

20 UNDERTAKER Wendell J. Lippich ADDRESS 308 E Columbia

(1) Cause should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 24 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001

E 21561 REGISTERED NO. E 21561

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1412 Light St St. 23-31 Ward)

2-FULL NAME Dr Clarence P Erken Brack

(a) RESIDENCE NO. 1412 Light St St. 23 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed or divorced HUSBAND of Teresa (or) WIFE of Teresa Rose

6 DATE OF BIRTH (month, day, and year) June 1880

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
47	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physican

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York

PARENTS

10 NAME OF FATHER Fred Erken Brack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Isabelle Beresford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Teresa Teresa Erken Brack

(Address) 1412 Light St

15 Filed APR 24 1927 by C. Hall Jones M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 22, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to April 22, 1927, that I last saw him alive on April 22, 1927, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem Date of Burial 4/25 1927

20 UNDERTAKER Thos F. Kelly & Sons ADDRESS 21 Eight St.

DO NOT write in this space. Any space not needed for answers should be ruled. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21562.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 E 21562

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mollie Smith

(a) RESIDENCE NO. Hurlock, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 41; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant C. Hampton Jones M.D.

(Address) Federalsburg Md

15 Filed ..... 19..... C. HAMPTON JONES, M. D. Registrar

APR 24 1927 Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15 1927, to April 23, 1927, that I last saw h.... alive on April 23, 1927, and that death occurred, on the date stated above, at 8.00 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ..... yrs. 12 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M.(D.

April 23 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hurlock, Md. Date of Burial 4/25 1927

20 UNDERTAKER: Wm J. Dickson & Son Emma R. Nolle ADDRESS

DO NOT FAIL TO CAREFULLY SUPPLY AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21563

CERTIFICATE OF DEATH.

35 ✓ **E 21563**

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 16-37

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Reiveliss

(a) RESIDENCE NO. [redacted] St. [redacted] Ward [redacted]

(Usual place of ~~abode~~) [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Logger Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 011

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) [redacted]

15 Filed [redacted] 19 [redacted] C. Earl Jones, M. D. Registrar

APR 25 1927 Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1926, to April 22, 1927, that I last saw h.xxx alive on April 21, 1927, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Bilateral Tuberculosis of Lungs

Arterial Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) B. Hooper Lunt, M. D.

April 22, 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

Date of Burial: April 25 1927

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

Do not use ditto marks. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

John T. Waters

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21564

CERTIFICATE OF DEATH.

49 E 21564

REGISTERED NO...

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 E. Valley St 10-14 St.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Waters

(a) RESIDENCE. NO. 919 Valley St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Waters

6 DATE OF BIRTH (month, day, and year) Feb. 4-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Hochschild K&m Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A Reeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna C. Waters (Sister) (Address) 919 Valley St.

15 Filed APR 25 1927 19 C. EMMETT JONES, M. D. Registrar Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1927

17 I HEREBY CERTIFY, That I attended deceased from H-10, 1927, to 4-21, 1927, that I last saw him alive on H-20, 1927, and that death occurred, on the date stated above, at 11 P.M. m.

The CAUSE OF DEATH* was as follows:

Cedmo carcinoma of cervical glands

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Keare, M. D.

19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Apr. 25 1927

20 UNDERTAKER John M. Johnson

ADDRESS 1234 Edmondson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21565

CERTIFICATE OF DEATH.

E 21565

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 15-65 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Nathan Pletkin~~

(a) RESIDENCE NO. 4003 Norfolk Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Pletkin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Pletkin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Mary Pletkin

(Address) 4003 Norfolk Ave

15 Filed ..... 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gas inhalation (own)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) D. T. Kenney M. D.
(Coroner)

April 25, 19 24 (Address) 2817 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Comet Date of Burial 4/25 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

Iron should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 25 1927 HEALTH DEPT. BALTIMORE, MD.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21566
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

166 ✓ +

E 21566
REGISTERED NO.

City of BALTIMORE: (No. St, Agnes Hosp 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Dorfch

(a) RESIDENCE NO. 2016 Eagle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Dorfch

6 DATE OF BIRTH (month, day, and year) — Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Tublin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Baskin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Max Dorfch
(Address) 2016 Eagle St.

15 Filed APR 25 1927 HARRY J. JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 22nd 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by Inquest
find that said deceased came to her death
(autopsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning
(Duration) yrs. mos. 5 ds.
Suicide

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos. B. Hortin M. D.
(Coroner)
Apr 23 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths due to Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial
Retreat Mt Carmel 4/25 1927

20 UNDERTAKER ADDRESS
Jack Lewis 1439 Eutaw

See back of this sheet before signing. Be sure to give FULL DATE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21567

CERTIFICATE OF DEATH.

90

E 21567

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Washington

(a) RESIDENCE NO. 1809 Madison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Washington

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) O.H.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER James Martin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Lizzie Bonnie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant (Address) Records

15 Filed APR 25 1927 C. HASTINGS JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 22, 1927, that I last saw h.. alive on April 22, 1927, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Myocardial hypertrophy & Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) [illegible] Hooper Smith, M. D.

(Address) [redacted] MORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL (Name of Cemetery) Date of Burial

Edmondson Va April 25 1927

UNDERTAKER ADDRESS

Thomas Funeral Home

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Webb

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21568

CERTIFICATE OF DEATH.

90

E 21568

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

2-FULL NAME Joseph Webb

(a) RESIDENCE NO. Dulaney Valley St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8th 1849

7 AGE: Years 77 7/8 | Months 7 | Days 15 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Webb

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Rose Lindt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Dulaney Valley

15 Filed_____ 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

April 23rd

17 I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to ....., 19.....,

that I last saw h[illegible] alive on April 17, 1927,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ....., Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Wanna, M. D.

April 29, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral. Date of Burial: April 25 1927

20 UNDERTAKER: Rita Wendfeld ADDRESS: 914 Gruman Ave

DO NOT WRITE IN SPACE BELOW. ALL ITEMS SHOULD BE CAREFULLY SUPPLIED. ANSWERS SHOULD BE GIVEN IN PLAIN ENGLISH. PHYSICIANS SHOULD STATE CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21569

CERTIFICATE OF DEATH.

179 E 21569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(a) NO. 1800 E Chilton ST. 9-4th (WARD)

2-FULL NAME Thomas A. Burnett

(a) RESIDENCE NO. 1800 E Chilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah E. Burnett

6 DATE OF BIRTH (month, day, and year) Dec 5, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	56	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Ship Repair Co

(c) Name of employer

9 BIRTHPLACE (city or town) Chriefield (State or country) Md

PARENTS

10 NAME OF FATHER Solomon Burnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary E. Mason

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Sarah Burnett (Address) 1800 E Chilton St

15 Filed ....., 19 C. HAMPTON JONES, M. D. Registrar

APR 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 7 1927 to Apr 23 1927.

that I last saw h~~im~~ alive on Apr 22 1927.

and that death occurred, on the date stated above, at 8 20 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac + Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse Nephritis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C. E. Richey M. D.

Apr 25 1927 (Address) 1301 N Pat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL April 26 1927

UNDERTAKER Henry Lutz

ADDRESS 1203 N Broadway

Spec.–7-17-26—A Co.—200 Bks.

E 21570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21570

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33rd + Calvert St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Otto Gleichman

(a) RESIDENCE NO. 1639 Abbottston St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Gleichman

6 DATE OF BIRTH (month, day, and year) Mar. 13. 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	46	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Theodore Gleichman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Lehr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Meta Gleichman

(Address) 1639 Abbottston st

15 Filed APR 25 1927 H. A. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-16 1927 to 4-23 1927

that I last saw h.. alive on 4-23 1927

and that death occurred, on the date stated above, at 11.50 am

The CAUSE OF DEATH* was as follows:

acute appendicitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2½ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 4-16-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. F. Ballard M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial Apr 26 1927

20 UNDERTAKER Geneys - J. Ruth ADDRESS 1735 Harford Ave

(Do not abbreviate or use ditto marks. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—1-12-23—M&T—500 Bks.

See Letter on file from Dr P. J. Motta dated 5/16/27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21571 — E 21571

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 24-33 ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Brocato

(a) RESIDENCE NO. 1401 Riverside Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Louise Brocato

6 DATE OF BIRTH (month, day, and year) Nov 23 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
32	32	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Salvatore Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonina Bianca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Cicero

(Address) 1214 N. Caroline st

15 Filed APR 25 1927 H. LEWIS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to April 23, 1927, that I last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. J. Motta M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 26th 1927

20 UNDERTAKER Frank V. Pipitone

ADDRESS 1818 E. Balto St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 21572

CERTIFICATE OF DEATH

E 21572

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. The Cecil Apartments St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Hopkins Cowman

(a) RESIDENCE NO. The Cecil Apts. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 67 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 90 yrs. 3 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel S.Cowman

6 DATE OF BIRTH (month, day, and year) January-3-1837

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	90	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) A.A.County

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Lambert Hopkins

11 BIRTHPLACE OF FATHER (City or town) A.A.County

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Hopkins

13 BIRTHPLACE OF MOTHER (city or town) A.A.Co.

(State or country) Maryland

14 Informant Miss Harriet H.Cowman(daughter)

(Address) Cecil Apts, City.

15 Filed APR 25 1927 H. M. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1927. to April 23rd, 1927.

that I last saw her alive on April 23rd, 1927.

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia, beginning as Bronchitis, of the Broncho-pneumonia of

about 4 8 Days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eoldidge C. Price, M. D.

4-24, 1927 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. Friends' Burying Ground — Date of Burial: Apr-25-1927

20 UNDERTAKER: STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

...ation should be carefully supplied. AGE should be stated EXACTLY. ...ate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa... very important. See instructions on back of certificates. ...CUPATION is

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21573

CERTIFICATE OF DEATH

89

E 21573

REGISTERED NO.

15-61

1-PLACE OF DEATH

City of BALTIMORE: (No. 3510 Powhatan-Av. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Sophia Moore

(a) RESIDENCE NO. 3510-Powhatan-Av St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 76 yrs. 5 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Hanson Moore

6 DATE OF BIRTH (month, day, and year) November-20-1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	76	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Charles Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Burch

11 BIRTHPLACE OF FATHER (City or town) ? ? ?

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Miss Howard ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. R. Maurice Miller (daughter)

(Address) 3510-Powhatan-Av., City.

15 Filed ..... 19 .... Registrar

APR 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Apr. 23- 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22, 1927, to Apr. 23, 1927, that I last saw h.. alive on Apr. 23, 1927, and that death occurred, on the date stated above, at 9 P M m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Heart block

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. G. Prentiss, M. D.

. 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

Date of Burial Apr-26-27 19

26 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

...tion should be carefully supplied. AGE should be stated EXACTLY. ...ICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

199 E 21574

E 21574 PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md General Hospital ST. 17-20 WARD)

2-FULL NAME Mrs Marie Triggs

(a) RESIDENCE NO. 2021 Maryland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	M

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Howard Triggs

6 DATE OF BIRTH (month, day, and year) 7-27-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm F Webster

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jane Connor

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ..... 19 C. HAYS JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23 1927

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to April 23, 1927, that I last saw h.. alive on April 23, 1927, and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic Inflammatory Disease (acute)

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral abscess

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. C. Hampton M. D.

4/26/27 (Address) 1 W Mt Clare Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Apr 26 1927

UNDERTAKER William Cook ADDRESS 508 E Madison

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21575

CERTIFICATE OF DEATH.

E 21575

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 7 5-72 Ward)

REGISTERED NO...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm P. Murphy

(a) RESIDENCE No. Hopkins Ave - Hollins St. Md Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. 1 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60 61				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Stephen Murphy
(Address) Hopkins Ave Baltimore

15 Filed APR 25 1927, 19 C. [illegible] JONES, M. D.
Registrar
Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1927, to 4-24, 1927, that I last saw him alive on 4-24, 1927, and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
and lobar Pneumonia
involving both lungs

(duration) yrs. mos 3. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) J. Theron Sumner M. D.

4/24 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Apr 26 19 27

20 UNDERTAKER Wilson Cook — ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21576

CERTIFICATE OF DEATH

90

E 21576

REGISTERED NO.

27-55

1-PLACE OF DEATH

City of BALTIMORE: (No. 6017 Shelbourne Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Filleta Wilhelm,

(a) RESIDENCE NO. 6017 Shelbourne Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Frank Wilhelm,

6 DATE OF BIRTH (month, day, and year) August 3, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	72	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm. H. Gross,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Eliza Grub,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant J. Frank Wilhelm,

(Address) 6017 Shelbourne Ave.

15 Filed APR 25 1927, 19... C. RAWSON JONES, M. D.

Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 23 1927 19...

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1926, to Apr 23, 1927

that I last saw her alive on Apr 23, 1927

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertension

(duration) ... yrs. 6 mos. ... da.

CONTRIBUTORY (Secondary) None.

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

4-24, 19 27 (Address) 3002 Garrison Ca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: APR 26 1927 19...

20 UNDERTAKER: Geo W Little — ADDRESS: 2766 EDMONDSON AVE.

How should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 21577

CERTIFICATE OF DEATH.

E 21577

1-PLACE OF DEATH

REGISTERED NO.

22-31

City of BALTIMORE: (No. 13 N. Church St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Washington McKnight.(C)

(a) RESIDENCE NO. 13 N. Church St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~(or WIFE of)~~ Elizabeth McKnight.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE: Years 80; Months ---; Days ---; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) South Carolina.

PARENTS

10 NAME OF FATHER Lawrence McKnight(

11 BIRTHPLACE OF FATHER (city or town):

(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Sarah Lee.(C)

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) South Carolina.

14 Informant Elizabeth McKnight.(C) wife.

(Address) 13 N. Church st.

15 Filed ....., 19 ..... Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) H. Ziegenfuss M. D. (Coroner)

4/25 19 27 (Address) 1017 St. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Jam Date of Burial 4. 25. 1927

20 UNDERTAKER: R. L. Parham ADDRESS 1246 Saha...

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 25 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21578

CERTIFICATE OF DEATH.

100-001

E 21578

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1234 S Sharp St Ward 23-31)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martha Robinson

(a) Residence No. 1234 S. Sharp St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colord

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) Jan 1-1870

7-AGE. 57

58 yrs. 3 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of industry, business, or establishment in which employed (or employer). 37

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). N. C.

PARENTS.

10-NAME OF FATHER. John Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. C.

12-MAIDEN NAME OF MOTHER. Mary Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. C.

14- (Informant) Ida Baker

(Address) 1234 S. Sharp St.

15- Filed ..... 19.. Per ..... Registrar.

APR 25 1927 C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-22-27

17- I HEREBY CERTIFY, That I attended deceased from 4-12 1927, to 4-22 1927, that I last saw her alive on 4-22 1927, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Meningeal Broncho Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Subacute Bacterial Endocarditis

(Duration) yrs. mos. 2 1 ds.

18-Where was disease contracted if not at place of death? 7 2w

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampton Jones, M. D.

, 19 (Address) 615 N. Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Hope

DATE OF BURIAL. 4-25 1927

20-UNDERTAKER. D R L Parham

ADDRESS 1216 E. Sharp St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 21579

CERTIFICATE OF DEATH.

E 21579

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 228 N Strieker St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gaitker

(a) RESIDENCE NO. 228 N. Strieker St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 4-23-27

7 AGE	Years	Months	Days 0 /	IF LESS than 1 day, __ hrs. or __ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Gaitker

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Williams

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md

14 Informant Mabel Reeves

(Address) 226 N Strieker St

15 Filed APR 25 1927 C. HARRISON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-1927

17 I HEREBY CERTIFY, That I attended deceased from 4-23-1927, to 4-24-1927, that I last saw him alive on 4-24-1927, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows: Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Carlson, M. D.

4/24 1927 (Address) 808 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon

Date of Burial 4/27 1927

20 UNDERTAKER Lewis J. Beasley & W. Biddle

ADDRESS 518

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21580

2022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 21580

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Miller (Kavaler)

(a) RESIDENCE NO. 1102 S. Curley St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of =

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE: Years 20 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electricians Helper

(b) General nature of industry, business, or establishment in which employed (or employer): Md.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Angez

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 25 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 24, 1927, that I last saw h~~im~~ alive on April 24, 1927, and that death occurred, on the date stated above, at 1:25 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis. Hypertension.

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Intra abdominal hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urobilinuria.

(Signed) Christopher Johnston, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary Cem. Date of Burial 4-27 1927

20 UNDERTAKER Stephen J. Traitorio ADDRESS 1[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 21581 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 21581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Elliott st. ST., 1-1 WARD)

2-FULL NAME Michael Jaszek.

(a) RESIDENCE NO. 3014 Elliott st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Leonora Jaszek.

6 DATE OF BIRTH (month, day, and year) April 22-1877

7 AGE: Years 50. Months Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Thomas Jaszek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Waterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Leonora Jaszek.

(Address) 3014 Elliott Street

15 Filed APR 25 1927, 19 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 24, 1927, that I last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis, arteriosclerosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) Jos. A. Rosenstein M. D.

4/25, 1927 (Address) 3080 O'Donnell St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus

DATE OF BURIAL: April 27 1927

20 UNDERTAKER: George A. Weber

ADDRESS: 2205 Bank st

Cor.—12-9-25—A Co.—200 Bks.

E 21582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 21582

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar F. Shindeldecker

(a) RESIDENCE NO. 3027 Elliott St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 18/25

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Palto., Md.

PARENTS

10 NAME OF FATHER Harrison Shindeldecker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Beulah Monn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Beulah Shindeldecker

(Address) 3027 Elliott St

15 Filed APR 25 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia- prob Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Zeiler M. D.

(Coroner)

4/29/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnsons Cem. Date of Burial 19

20 UNDERTAKER Lilly & Zeiler ADDRESS 703 S. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21583

CERTIFICATE OF DEATH.

9-902

E 21583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 8-16 Ward)

2-FULL NAME Harry F. Wills

(a) RESIDENCE NO. 1602 N. Bradford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Wills

6 DATE OF BIRTH (month, day, and year) March 19/88

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm G. Wills

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Henderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Emma Wills

(Address) 1602 N. Bradford St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/27 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abcess left Antrum (Sepsis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Wilson M. D.
(Coroner)

4/25/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial April 25th 1927

20 UNDERTAKER Lee DeLoach ADDRESS 1723 Park Ave

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21584

CERTIFICATE OF DEATH.

129 E 21584

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3248 Barclay ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter T. Walker

(Residence in Baltimore: No. 3248 Barclay st. St.; 62 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, December, 1865
(Month) (Day) (Year)

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm Walker

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margt Walker

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgiana Walker

(Address) 3248 Barclay

15-

Filed ..... 191..

By ..... Registrar.

C. HAMPSON JONES, M. D.

APR 25

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23rd, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from abt 1 1917, to abt 22 1917, that I saw h— alive on abt 22 1917, and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
with hypertrophy
Dilatation

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 3 yrs. mos. do.

(Signed) H. J. Stuebe Jr M. D.

Apr. 25, 1917. (Address) 632 Gorsuch ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	April 26 1917
20-UNDERTAKER	ADDRESS
Wm. H. Elliott	1325 Ashland Av

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52

REGISTERED E 21585

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 332 N Caroline (Ward) 3-4

2-FULL NAME Amelia Bell

(a) RESIDENCE NO. 332 S. Caroline st. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga. Ga.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mattie A Hollis

(Address) 332 S. Caroline st.

Filed APR 25 19 C. HAMPTON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10 1/2, 1927, to April 22nd, 1927, that I last saw h[illegible] alive on , 1927, and that death occurred, on the date stated above, at 10.25 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Weinman, M. D.

4/24, 19 27 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Apr 25 1927
Undertaker Mrs. R. A. Elliott	Address 1745 Garrison Av.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 21586

1-PLACE OF DEATH

City of BALTIMORE: (No. 760 N Hanburg St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Hardesty

(a) RESIDENCE NO. 760 N Hanburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
RUSBAND of
(or) WIFE of Geo W Hardesty

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ipswich

(State or country)

PARENTS

10 NAME OF FATHER Samal Copper

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Hannah Wales

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mr James Harding

(Address) 760 N Hanburg St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Intussisception

Ileum

not struck

Interrupt by fecal mass

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hy Pertrophy

(duration) yrs. mos. ds.

(Signed) Hamil Hershey M. D.
(Coroner)

19 27 (Address) 3325 Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bolt J Lamm's

Date of Burial 25 April 1927

20 UNDERTAKER Cecil Hill

ADDRESS 1441 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 21587

CERTIFICATE OF DEATH.

E 21587

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2492 Schroeder St. 10-76

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hagan

(a) RESIDENCE NO. 2492 Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Hagan

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years: about 74 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Frederick

(State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town):

(State or country):

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country):

14 Informant: Edwin Cornish

(Address): 2492 Schroeder St.

15 Filed ..... 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel S. Taylor M. D.

(Coroner)

19 27 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: April 25, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

APR 23 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21588

CERTIFICATE OF DEATH.

129

E 21588

REGISTERED NO.

1-PLACE OF DEATH 2725 E. Monument St

CITY OF BALTIMORE: (No ~~1000 Glenwood Ave~~ ward 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Wood

(a) RESIDENCE No 1000 Glenwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Wood

6 DATE OF BIRTH (month, day, and year): June 6, 1906

7 AGE — Years: 20 — Months: 10 — Days: 16 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles A. Bateman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Kellyn Grace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Hungerford L. Wood

(Address) 1000 Glenwood Ave

15 Filed APR 25 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1927, to Apr 22, 1927, that I last saw h[illegible] alive on Apr 21st, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Bright's Disease with La Grippe and Heart complications

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): La Grippe (Bronchial)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Apr 25 1927

UNDERTAKER: Harry H. Witzke

ADDRESS: 1831 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21589 E 21589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 17-50 153 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delano J Hanzsche

(a) RESIDENCE No. 2936 St Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Helen Hanzsche

6 DATE OF BIRTH (month, day, and year) May 15 1903

7 AGE: Years 23; Months 11; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeping

(b) General nature of industry, business, or establishment in which employed (or employer) Independent Iron

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward Hanzsche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Allie Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edward Hanzsche

(Address) 2936 St Paul St

15 Filed APR 25 1927, 19 Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1927, to Apr 24, 1927, that I last saw h[illegible] alive on Apr 24, 1927, and that death occurred, on the date stated above, at 805 m.

The CAUSE OF DEATH* was as follows:

Cellulitis of back due to

Streptococcus Hemolyticus

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Septicaemia (Strep Hemolytic

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/21/27

Was there an autopsy? No

What test confirmed diagnosis? Laboratory culture

(Signed) F L Lusby, M. D.

4/24, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Apr. 26, 1927

UNDERTAKER: Joseph B Cook

ADDRESS: 1003 Madison St

SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec. -7-17-26—A Co.—200 Bks.

E 21590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-002

E 21590

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 56 Forest Ave., Hillsdale St. 28-65 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Kunert

(a) RESIDENCE NO. 56 Forest Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Kunert

6 DATE OF BIRTH (month, day, and year) August 11th. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	66	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Kunert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Marie Kunert

(Address) Hillsdale, Md.

15 Filed APR 25 1927 H. C. HAWKINS JONES M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1927, to April 22, 1927,

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Rheumatic endocarditis

(duration) ...yrs. 1 mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. C. Lumb, M. D.

4/22, 1927 (Address) Liberty Heights Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorriane Cemetery — Date of Burial Apr. 25 1927

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21591

CERTIFICATE OF DEATH

129 E 21591

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1439 Covington St. 24 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Ulrich

(a) RESIDENCE NO. 1439 Covington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 22 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Ulrich

6 DATE OF BIRTH (month, day, and year): July 11 1880

7 AGE — Years: 46 Months: 9 Days: 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John L Butler

11 BIRTHPLACE OF FATHER (City or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Fenton Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Northumberland Co Va

14 Informant: Mrs Fenton Butler

(Address) 1133 William st

15 Filed APR 25 1927 C. HAINES JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 1, 1927, to April 23, 1927, that I last saw h. alive on April 23, 1927, and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH was as follows: Cerebral Hemmhage

(duration) yrs. mos. 1 dy

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Eye

(Signed) C Mitchell M. D.

4/25. 1927 (Address) 1279 William st

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: April 27 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 L. St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 21592 — 1-PLACE OF DEATH — REGISTERED NO. E 21592

City of BALTIMORE: (No. 802 W. Franklin St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Page

(a) RESIDENCE NO. 802 W. Franklin St. Ward

(Usual place of abode) unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE: Years 36 Months Days IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer): 083

(c) Name of employer: Penn.

9 BIRTHPLACE (city or town) ... (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town) ... (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) unknown

14 Informant Frank Price, Jr. (Address) 802 W. Franklin

15 Filed APR 25 1927 Per ... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb ..., 1927, to April 22, 1927, that I last saw h... alive on April 22, 1927, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

4/22/1927 (Address) 1424 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery — Date of Burial: Apr. 26 1927

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 614 N. Carolina St.

DO NOT FAIL to have this certificate filled out and signed. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Pks.

Bergan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21593

CERTIFICATE OF DEATH.

109-002

E 21593

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. (or WARD)

2-FULL NAME Baby Robert Burgen

(a) RESIDENCE No. Westminster, Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-31-1926

7 AGE: Years ... Months 8 Days 27 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Edmund Burgen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Pebbering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records

(Address)

15 Filed APR 25 1927, C. HAYDEN JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-23-27, 19 ... to 4-24-27, 19 ...

that I last saw h/M alive on 4-24-27, 19 ...

and that death occurred, on the date stated above, at 10:30 a.m., p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (duration) ... yrs. ... mos 5 weeks ds.

CONTRIBUTORY (Secondary) Toxemia (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of 4-23-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M. D.

, 19 (Address) Maryland General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shilly Rock Co Pa

DATE OF BURIAL April 27 1927

20 UNDERTAKER H M Routson

ADDRESS 2238 N Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21594 — REGISTERED NO. 57 E 21594

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Butler

(a) RESIDENCE NO. 706 N. Central St. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant Reads

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. H. JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to April 23, 1927, that I last saw h— alive on April 23, 1927, and that death occurred, on the date stated above, at 4 9- m.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

Diabetic Gangrene ? cardiac

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 0

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Henry A Peterson, M. D.

, 19 (Address) Johns Hopkins Hosp 2464 700

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Asbury Cemty	4/26/ 1927

20 UNDERTAKER Byron Wright — ADDRESS 1218 McCulloh

APR 25 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 135

E 21595

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Craig

(a) RESIDENCE NO. 177 Strayer St. Johnstown Cambria Co. Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron mill

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa —

(State or country)

PARENTS

10 NAME OF FATHER William Craig

11 BIRTHPLACE OF FATHER (city or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hess

13 BIRTHPLACE OF MOTHER (city or town) Pa —

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... C. HAMILTON JONES, M. D. Registrar

R 25 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 - 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5 1927, to April 25 1927, that I last saw her alive on April 25 1927, and that death occurred, on the date stated above, at 5-25 a. m.

The CAUSE OF DEATH* was as follows: Benign Prostatic Hypertrophy

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? at Johnstown City Pa

Did an operation precede death? yes Date of April 18-27

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture

(Signed) Robert W. Mackay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa. Date of Burial Apr 25 1927

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Elmore Wright ✓

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21596

CERTIFICATE OF DEATH.

E 21596

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hosp. St. 11-24 Ward)

2-FULL NAME Elmore Wright

(a) RESIDENCE NO. 909 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1891

7 AGE: 35 Years 34 Months 3 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer: General

9 BIRTHPLACE (city or town): April 27

(State or country): Va.

PARENTS

10 NAME OF FATHER: Geo Wright

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Nancy Moss

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Gertrude Wright

(Address): Summit, N.J.

15 Filed APR 25 1927 C. H. VAN JONES, M. D. Registrar

Per K.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 6 mos. ds.

(Signed) C. H. Jones M. D. (Coroner)

(Address) 802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Lawn Date of Burial Apr 25 1927

20 UNDERTAKER: Samuel T. Hawley & W. Biddle ADDRESS 578

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21597

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5004 Reisterstown Rd ST., 27 WARD)

2-FULL NAME Mrs. Sarah E Brown

(a) RESIDENCE NO. 5004 Reisterstown Rd ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William J Brown

6 DATE OF BIRTH (month, day, and year) May 6, 1852

7 AGE 74 Years 11 Months 19 Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Cockeysville Balto. Co. Md

PARENTS

10 NAME OF FATHER Aquilla Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cockeysville Balto. Co. Md

12 MAIDEN NAME OF MOTHER Sarah Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jerusalem Balto. Co. Md

14 Informant Florence G. Brown (Address) 5004 Reisterstown Road

15 Filed 4 25 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23. 1927. to April 25. 1927. that I last saw her alive on April 24, 1927. and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Pulmonary Oedema

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Jones, M. D.

4-25-1927 (Address) 5106 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Church Cemetery Balto Co Md

DATE OF BURIAL April 25 1927

UNDERTAKER J. F. Ellis & Sons Reisterstown Md

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21598

CERTIFICATE OF DEATH. 21

E 21598

1-PLACE OF DEATH Balto City Hospts REGISTERED NO.

City of BALTIMORE: (No. Balto Md St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Fursch

(a) RESIDENCE NO 1738 Patapsco St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Mary Fursch

6 DATE OF BIRTH (month, day, and year) Jan 31st 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of indnstry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Ernest Fursch

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Dorothy Muench

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country) Unknown

14 Informant Balto City Hospts

(Address) Balto Md

15 Filed 4/25 1927 C. HAMPSON JONES, M. D. Registrar

Per ACR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-7- 1927 to 4-24 1927

that I last saw him alive on 4-23 1927

and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas of face—Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry J. O'Donnell M. D.

4/24/1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western Cem April 27 1927

20 UNDERTAKER ADDRESS

B Schloman Son 1004 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21599

CERTIFICATE OF DEATH.

19 4 E 21599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Old Gen Hosp ST. 1-3 WARD)

2-FULL NAME Michael Mishkowiak

(a) RESIDENCE NO. 2634 Hudson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Michael Mishkowiak

6 DATE OF BIRTH (month, day, and year): Mar. 24 1886

7 AGE — Years: 40 Months: 3 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Heater

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co

(c) Name of employer: Sparrows Point

9 BIRTHPLACE (city or town) (State or country): Pitts Pa

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Next Friends

(Address)

15 Filed 4 25 1927 C. HAMPSON JONES, M. D. Registrar

Per BPW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4-21-27 to 4-22-27

that I last saw him alive on 4-22-27 19

and that death occurred, on the date stated above, at 7:40 A m.

The CAUSE OF DEATH* was as follows:

Heat Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bethlehem Steel Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Arrival.

(Signed) Thos Gorsuch M. D.

19 Address Mt Clare Shops

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary cem

DATE OF BURIAL: April 26 1927

20 UNDERTAKER: John M Weber

ADDRESS: 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21600

CERTIFICATE OF DEATH.

E 21600

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 3 1 90

REGISTERED NO.

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gittings

(a) RESIDENCE NO. 115 W Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Gittings

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 [illegible] C. HARRISON JONES, M. D.

Registrar

APR 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to April 20, 1927, that I last saw h.m alive on April 20, 1927, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Myocardial hypertrophy & Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. H. Spencer Smith, M. D.

April 21 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing [redacted] If Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial April 23 1927

20 UNDERTAKER S. L. & J. Brown & Son ADDRESS 1118 Montgomery

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21601 ✓ 129 E 21601

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 316 S. Highland ave St., 1-2 Ward)

2-FULL NAME David Davis

(a) RESIDENCE NO 316 S. Highland ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 - 1841

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	85	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Self Employed

(c) Name of employer Street Cleaning

9 BIRTHPLACE (city or town) _____

(State or country) Wales

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Wales

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Wales

14 Informant Bessie Davis

(Address) 316 S. Highland ave

15 Filed 1927 C. HAMILTON JONES, M. D.

For R.C.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Years yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency following Nephritis (duration) yrs. mos. ds.

(Signed) James G. Hinton, M. D.

(Coroner)

4/2/ 1927 (Address) Jove Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Date of Burial 4/26 1927

20 UNDERTAKER W. J. Hickman Son ADDRESS Penna Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21602

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 68 Mallow Hill Road (Street) 26-71 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Emma Overholt.

(a) RESIDENCE No. 68 Mallow Hill Road St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. F. Overholt

6 DATE OF BIRTH (month, day, and year) March 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) McCalls Ferry (State or country) Pa

PARENTS

10 NAME OF FATHER Hugh Penny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Matilda Wentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Nellie E. Wenrich (Address) 68 Mallow Hill Rd

15 Filed ... 25 1927, 19 ... C. HAMPSON JONES, M.D. For ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1927, to Apr. 22, 1927, that I last saw h w alive on Apr. 22, 1927, and that death occurred, on the date stated above, at 7.15 P m

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency & Mitral regurgitation yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M B Cunningham, M. D.

(Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Level Pa DATE OF BURIAL Apr. 25 1927

20 UNDERTAKER Wm Flickner Sons ADDRESS Norristown Pa

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21603

HEALTH DEPARTMENT—CITY OF BALTIMORE

1903

E 21603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 27-41 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Naoma Givvines

(a) RESIDENCE NO. Harford nr Arizona Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXXX

6 DATE OF BIRTH (month, day, and year): Apr 30/1908

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	22	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attendant

(b) General nature of industry, business, or establishment in which employed (or employer): State Hospital

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: William Givvines

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto., Md.

14 Informant: Elizabeth Givvines

(Address): 2607 Eastern Ave

15 Filed 4 25 1927 G. HAMDEN JONES, M. D. Registrar

By RRB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 23/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage-fractured skull

Struck by automobile Harford Rd near Arizona Ave

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Bullen M. D.

(Coroner)

4/25/27 18 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

Date of Burial: Apr 26 1927

20 UNDERTAKER: John Ulrich

ADDRESS: 200 S Arlington Ave

If death occurred in private family, state fact. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21604

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. Bouldin ST., 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Nace

(a) RESIDENCE No. 116 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Savannah M. Nace

6 DATE OF BIRTH (month, day, and year) July 8-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Geo. Nace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Savannah M. Nace

(Address) 116 S. Bouldin St

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to April 24, 1927, that I last saw h in alive on April 24, 1927, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver Primary

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Observation

(Signed) Horace B Tilson M. D.

4/25, 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL April 26, 27

20 UNDERTAKER Zickler & Zickler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH must be plainly written. So that it may be properly classified. PENALTY for false statement of this information is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21605

161-91 E 21605

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 15-21 Ward)

2-FULL NAME Baby Wallace

(a) RESIDENCE NO. 721 Baker St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 18, 1927

7 AGE: Years | Months | Days | IF LESS than 1 day 14 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Wallace

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ala.

12 MAIDEN NAME OF MOTHER Ward Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed APR 25 1927, 19 C. HAMPSON JONES, M. D.

Per 1097 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4-18, 1927, to 4-18, 19 27

that I last saw him alive on 4-18, 19 27

and that death occurred, on the date stated above, at 8" a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (7mos)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Placenta previa

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health. APR 25 1927

Per [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21606

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Elizabeths Home St., 9-47 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Brown Hennigan

(a) Residence No. St Elizabeth Home, Chesnut Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 26 1926

7-AGE, 1 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Hennigan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant).....

(Address).....

15-

Filed ..... 192.....

C. EARNSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24 1927

17- I HEREBY CERTIFY, That I attended deceased from April 20 1927 to April 24 1927

that I last saw him alive on April 22 1927,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

.....(Duration).....yrs.....mos. 3 ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis?.....

(Signed) B. T. Herzog M. D.

4/26, 1927 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER, ADDRESS

APR 25 1927

1293

Instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21607

E 21607

CERTIFICATE OF DEATH.

1617-08

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St., 79 Ward)

2-FULL NAME Baby Boothe

(a) RESIDENCE NO Kingsville Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or 35 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) ....

(State or country) Md.

PARENTS

10 NAME OF FATHER William P. Boothe

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Tenn

12 MAIDEN NAME OF MOTHER Jenney A. Boothe

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Va.

14 Informant Records

(Address) Johns Hopkins Hospital.

15 Filed ....., 19 .... Registrar

1296 Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1927, to 4-20, 1927

that I last saw him alive on 4-20, 1927

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos. fetus)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? ....

(Signed) J. Whorner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19 ....

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

APR 25 1927

Commissioner Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21608

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21608

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 S. Potomac ST., 1-2 WARD)

2-FULL NAME Salvatore Salerno

(a) RESIDENCE NO. 639 S. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tresa Maiorana

6 DATE OF BIRTH (month, day, and year) Feb 4th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54.	2.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Bastiano Salerno

(Address) 2353 Lanetta ave

15 Filed APR 25 1927 C. HAMPSON JONES, M. D. Registrar

Per NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to April 23, 1927, that I last saw h— alive on April 23, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis - Alcohol

Nephritis

Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. Carlignani, M. D.

, 19 (Address) 2942 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 4/26 1927

20 UNDERTAKER Leo J. Ruth, 1735 Harford ave — ADDRESS

TION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

(Baker st)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21609

E 21609

CERTIFICATE OF DEATH.

REGISTERED NO. 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen ST. (or) WARD)

2-FULL NAME Lawson C Cole

(a) RESIDENCE NO. 252 Baker St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Cole

6 DATE OF BIRTH (month, day, and year) 4/7/82

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Hos. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) West Balt. Gen. Hosp

15 Filed 2 5 1927, 19 C. HAMILTON JONES, M. D. By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1927

17

I HEREBY CERTIFY, That I attended deceased from 4/20, 1927, to 4/24, 1927, that I last saw h[illegible] alive on 4/24, 1927, and that death occurred, on the date stated above, at 4 35 P m.

The CAUSE OF DEATH* was as follows:

Acute emphysema

(Duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Arnold H Jensen M. D.

4/27, 1927 (Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Apr. 27, 1927

20 UNDERTAKER Joseph H Cole

ADDRESS 1003 W Balto St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21610 E 21610

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Baltimore & Payson Sts

City of BALTIMORE: (No. German Aged Home St., 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Kolb

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1845

7 AGE: Years 82 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant Records German Aged Home

(Address) Balto & Payson Sts

15 Filed C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 19 27

17

I HEREBY CERTIFY, That I attended deceased from Dec 19 25, to April 24, 19 27, that I last saw h[illegible] alive on April 22nd, 19 27, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Houff, M. D.

, 19 (Address) 1843 W. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem Date of Burial Apr. 26 1927

20 UNDERTAKER: Joseph B Cook ADDRESS 1003 N Gilmor St

25 1927

Or death or the place of burial, or both, as the case may be, must be stated. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 S. Robinson St. 1-2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaria Sessa

(a) RESIDENCE NO. 129 S. Robinson ST., I WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug 25th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	63	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Sebastiano Castro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giovannina Liotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Sessa
(Address) 129 S. Robinson St

15 Filed APR 25 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1927, to Apr 22, 1927, that I last saw her alive on Apr 22, 1927 and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D'Distefano M. D.

Apr 23, 1927 (Address) 407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 26 1927

20 UNDERTAKER Frank V. Spitone

ADDRESS 2015 E. Balto. St

FROM is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21612 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 21612

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Callahan

(a) RESIDENCE NO. Huntington W. Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ ~~(or) WIFE of~~ Edward Callahan

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record

(Address)

15 Filed APR 25 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-27.

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927, to April 23, 1927.

that I last saw her alive on April 23, 1927.

and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic Cardio-Vascular disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Sheldon Eastland, M. D.

, 19 (Address) 1736 N. Calvert St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntingdon W. Va

DATE OF BURIAL 4-25 1927

20 UNDERTAKER Geo A Farley

ADDRESS 1805 E Fayette

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 21613

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., 1-13 WARD)

2-FULL NAME Charles Stinner

(a) RESIDENCE NO. 905 N Castle St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Anna Stinner

6 DATE OF BIRTH (month, day, and year) July 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	51	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Stinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Yabel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Margaret Wyer

(Address) 17 N Washington St

15 Filed ..... 19 ..... Registrar

Rec'd 1927 CARLTON J. S. M. D.

Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/14, 19 27, to 4/22, 19 27

that I last saw h.e alive on 4/22, 19 27

and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Ruptured Urethral Stricture

Extravasation of Urine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. Miller, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 4-26-27 19

20 UNDERTAKER Geo A Harley

ADDRESS 1800 W Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 21614

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21614

CERTIFICATE OF DEATH.

100-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Woodward St. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M Stump

(a) RESIDENCE. NO. 809 Woodward. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 29 1927

7 AGE — Years: — Months: 2 Days: 26 If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Chas H Stump

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mildred Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Charles H Stump (Address) 809 Woodward St

15 Filed ..., 19... HARRISON JONES, M. D. Registrar

APR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21st, 1927, to April 24, 1927, that I last saw her alive on April 24, 1927, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Lobar),

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) L. Humphreys, M. D.

(Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 4-26 1927

20 UNDERTAKER: Ernest B Harlan — ADDRESS: 115 E Mosher St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21615

E 21615

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1811 N. Montford Lane (Ward) 8-16

2-FULL NAME Eugene Berg

(a) RESIDENCE NO. 1811 N. Montford Lane ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Berg

6 DATE OF BIRTH (month, day, and year): 4/30/1863

7 AGE: Years 63; Months 11; Days 23; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Polisher

(b) General nature of industry, business, or establishment in which employed (or employer): Glass 086

(c) Name of employer: Maryland Union Works

9 BIRTHPLACE (city or town) (State or country): Lorraine France

PARENTS

10 NAME OF FATHER: Eugene

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lorraine France

12 MAIDEN NAME OF MOTHER: Jagell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lorraine France

14 Informant: Mrs Norman Evans

(Address): 1811 N Montford Ave

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11th 1927 to April 23rd 1927.

that I last saw him alive on April 22nd 1927

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Broken compensation)

(duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) H. E. Jolly, M. D.

April 25 1927 (Address) 811 E Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 4-26-27

20 UNDERTAKER: Bernard A Funk

ADDRESS: 73 x Poplar Grove St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21616

CERTIFICATE OF DEATH.

11-001

E 21616

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3038 Greenmount Ave. St. 12-50 Ward)

2-FULL NAME Alice L. Nelson

(a) RESIDENCE NO. 3038 Greenmount Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John L. Nelson

6 DATE OF BIRTH (month, day, and year) May 3 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Michal Duffy

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Clark

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Baltimore, Md.

14 Informant Mrs. Matilda Schultz

(Address) 3028 Greenmount Ave.

15 Filed ..... 19 ..... Registrar

APR 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from April 8th 19 27 to April 23rd 19 27

that I last saw ... alive on April 23rd 19 27

And that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Da Grippe

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam

(Signed) F. W. Thompson M. D.

4/25 19 27 (Address) 4002 E. 25 Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 4/26 1927

20 UNDERTAKER Mary M. Wiedefeld ADDRESS 501 E. 22 St.

Be careful to print plainly, and use only black ink. Do not abbreviate. Give number of house if possible. Fill in all blanks for which you have data. Be particular and exact. Name and surname of deceased must be given in full, and the maiden name of every married woman. Write the word "None" where there is no entry to be made, except in the case of "Date of Death" and "Color or Race." Give exact date of birth in each case and the age at last birthday. In the case of infants, the age should be given in days if less than one day, in months if less than one year. The space for "Occupation" must be filled in with the actual occupation of every person dying, whether male or female, whether single, married, widowed or divorced. The entry must show not only the trade, profession or particular kind of work, but also the general nature of the industry, business or establishment with which the deceased was connected, thus supplying the information required to properly classify the occupation. See instructions on back of certificates. This certificate must be filled out in full, and the physician must sign his name and address. Carefully read the certificate before signing. Cause of death must be stated in plain English. Indefinite terms, such as "Debility," "Old Age," "Paralysis," "Heart Failure," "Convulsions," "Cancer," "Tumor," "Abscess," "Child Birth," "Fever," "Inflammation," "Hemorrhage," "Accident," "Suicide," "Homicide," "Drowning," "Found Dead," "Burns," "Scalds," "Fracture," "Contusion," "Sunstroke," "Lockjaw," "Blood Poisoning," "Gangrene," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Tuberculosis," "Consumption," "Pneumonia," "Typhoid Fever," "Malarial Fever," "Scarlet Fever," "Measles," "Whooping Cough," "Diphtheria," "Membranous Croup," "Erysipelas," "Smallpox," "Varicella," "Cholera Infantum," "Cholera Morbus," "Dysentery," "Diarrhoea," "Jaundice," "Stillborn," "Premature Birth," "Congenital Debility," "Malformation," "Marasmus," "Inanition," "Cachexia," "Exhaustion," "Infection," "Intoxication," "Septic Poisoning," "Septic Infection," "Septic Intoxication," "Gastritis," "Enteritis," "Gastro-Enteritis," "Colitis," "Entero-Colitis," "Nephritis," "Bright's Disease," "Peritonitis," "Appendicitis," "Ulceration of Stomach," "Ulceration of Intestines," "Stomach Disease," "Intestinal Disease," "Bowel Disease," "Liver Disease," "Kidney Disease," "Disease of Heart," "Valvular Disease of Heart," "Brain Disease," "Disease of Lungs," "Womb Disease," "Disease of Bladder," "Disease of Prostate Gland," "Locomotor Ataxia," "Paralysis Agitans," "Sclerosis," "Cirrhosis," "Fatty Degeneration," "Obstruction," "Duodenal Ulcer," "Carcinoma," "Sarcoma," "Adenoma," "Fibroma," "Myoma," "Neuroma," "Papilloma," "Epithelioma," "Chondroma," "Lipoma," "Osteoma," "Angioma," "Glioma," "Hydrocephalus," "Spina Bifida," "Ascites," "Anasarca," "Pleurisy," "Pericarditis," "Endocarditis," "Abortion," "Ectopic Gestation," "Puerperal Convulsions," "Puerperal Septicemia," "Puerperal Eclampsia," "Puerperal Hemorrhage," "Puerperal Fever," "Puerperal Peritonitis," "Puerperal Abscess," "Puerperal Mania," "Puerperal Pyemia," "Puerperal Uremia," "Puerperal Infection," "Puerperal Intoxication," "Puerperal Septic Poisoning," "Puerperal Septic Infection," "Puerperal Septic Intoxication," "Puerperal Gastritis," "Puerperal Enteritis," "Puerperal Gastro-Enteritis," "Puerperal Colitis," "Puerperal Entero-Colitis," "Puerperal Nephritis," "Puerperal Bright's Disease," "Puerperal Peritonitis," "Puerperal Appendicitis," "Puerperal Ulceration of Stomach," "Puerperal Ulceration of Intestines," "Puerperal Stomach Disease," "Puerperal Intestinal Disease," "Puerperal Bowel Disease," "Puerperal Liver Disease," "Puerperal Kidney Disease," "Puerperal Disease of Heart," "Puerperal Valvular Disease of Heart," "Puerperal Brain Disease," "Puerperal Disease of Lungs," "Puerperal Womb Disease," "Puerperal Disease of Bladder," "Puerperal Disease of Prostate Gland," "Puerperal Locomotor Ataxia," "Puerperal Paralysis Agitans," "Puerperal Sclerosis," "Puerperal Cirrhosis," "Puerperal Fatty Degeneration," "Puerperal Obstruction," "Puerperal Duodenal Ulcer," "Puerperal Carcinoma," "Puerperal Sarcoma," "Puerperal Adenoma," "Puerperal Fibroma," "Puerperal Myoma," "Puerperal Neuroma," "Puerperal Papilloma," "Puerperal Epithelioma," "Puerperal Chondroma," "Puerperal Lipoma," "Puerperal Osteoma," "Puerperal Angioma," "Puerperal Glioma," "Puerperal Hydrocephalus," "Puerperal Spina Bifida," "Puerperal Ascites," "Puerperal Anasarca," "Puerperal Pleurisy," "Puerperal Pericarditis," "Puerperal Endocarditis," "Puerperal Abortion," "Puerperal Ectopic Gestation," "Puerperal Puerperal Convulsions," "Puerperal Puerperal Septicemia," "Puerperal Puerperal Eclampsia," "Puerperal Puerperal Hemorrhage," "Puerperal Puerperal Fever," "Puerperal Puerperal Peritonitis," "Puerperal Puerperal Abscess," "Puerperal Puerperal Mania," "Puerperal Puerperal Pyemia," "Puerperal Puerperal Uremia," "Puerperal Puerperal Infection," "Puerperal Puerperal Intoxication," "Puerperal Puerperal Septic Poisoning," "Puerperal Puerperal Septic Infection," "Puerperal Puerperal Septic Intoxication," "Puerperal Puerperal Gastritis," "Puerperal Puerperal Enteritis," "Puerperal Puerperal Gastro-Enteritis," "Puerperal Puerperal Colitis," "Puerperal Puerperal Entero-Colitis," "Puerperal Puerperal Nephritis," "Puerperal Puerperal Bright's Disease," "Puerperal Puerperal Peritonitis," "Puerperal Puerperal Appendicitis," "Puerperal Puerperal Ulceration of Stomach," "Puerperal Puerperal Ulceration of Intestines," "Puerperal Puerperal Stomach Disease," "Puerperal Puerperal Intestinal Disease," "Puerperal Puerperal Bowel Disease," "Puerperal Puerperal Liver Disease," "Puerperal Puerperal Kidney Disease," "Puerperal Puerperal Disease of Heart," "Puerperal Puerperal Valvular Disease of Heart," "Puerperal Puerperal Brain Disease," "Puerperal Puerperal Disease of Lungs," "Puerperal Puerperal Womb Disease," "Puerperal Puerperal Disease of Bladder," "Puerperal Puerperal Disease of Prostate Gland," "Puerperal Puerperal Locomotor Ataxia," "Puerperal Puerperal Paralysis Agitans," "Puerperal Puerperal Sclerosis," "Puerperal Puerperal Cirrhosis," "Puerperal Puerperal Fatty Degeneration," "Puerperal Puerperal Obstruction," "Puerperal Puerperal Duodenal Ulcer," "Puerperal Puerperal Carcinoma," "Puerperal Puerperal Sarcoma," "Puerperal Puerperal Adenoma," "Puerperal Puerperal Fibroma," "Puerperal Puerperal Myoma," "Puerperal Puerperal Neuroma," "Puerperal Puerperal Papilloma," "Puerperal Puerperal Epithelioma," "Puerperal Puerperal Chondroma," "Puerperal Puerperal Lipoma," "Puerperal Puerperal Osteoma," "Puerperal Puerperal Angioma," "Puerperal Puerperal Glioma," "Puerperal Puerperal Hydrocephalus," "Puerperal Puerperal Spina Bifida," "Puerperal Puerperal Ascites," "Puerperal Puerperal Anasarca," "Puerperal Puerperal Pleurisy," "Puerperal Puerperal Pericarditis," "Puerperal Puerperal Endocarditis," "Puerperal Puerperal Abortion," "Puerperal Puerperal Ectopic Gestation," are not sufficient. Give the primary cause of death, and the secondary cause, if any, and the contributory cause, if any. Do not give the mode of dying, such as "Collapse," "Coma," "Asphyxia," "Shock," "Syncope," "Weakness," "Failure," "Arrest," "Cessation," "Stoppage," "Suppression," "Retention," "Ischemia," "Anemia," "Hemorrhage," "Thrombosis," "Embolism," "Rupture," "Laceration," "Wound," "Injury," "Fracture," "Contusion," "Sunstroke," "Lockjaw," "Blood Poisoning," "Gangrene," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Tuberculosis," "Consumption," "Pneumonia," "Typhoid Fever," "Malarial Fever," "Scarlet Fever," "Measles," "Whooping Cough," "Diphtheria," "Membranous Croup," "Erysipelas," "Smallpox," "Varicella," "Cholera Infantum," "Cholera Morbus," "Dysentery," "Diarrhoea," "Jaundice," "Stillborn," "Premature Birth," "Congenital Debility," "Malformation," "Marasmus," "Inanition," "Cachexia," "Exhaustion," "Infection," "Intoxication," "Septic Poisoning," "Septic Infection," "Septic Intoxication," "Gastritis," "Enteritis," "Gastro-Enteritis," "Colitis," "Entero-Colitis," "Nephritis," "Bright's Disease," "Peritonitis," "Appendicitis," "Ulceration of Stomach," "Ulceration of Intestines," "Stomach Disease," "Intestinal Disease," "Bowel Disease," "Liver Disease," "Kidney Disease," "Disease of Heart," "Valvular Disease of Heart," "Brain Disease," "Disease of Lungs," "Womb Disease," "Disease of Bladder," "Disease of Prostate Gland," "Locomotor Ataxia," "Paralysis Agitans," "Sclerosis," "Cirrhosis," "Fatty Degeneration," "Obstruction," "Duodenal Ulcer," "Carcinoma," "Sarcoma," "Adenoma," "Fibroma," "Myoma," "Neuroma," "Papilloma," "Epithelioma," "Chondroma," "Lipoma," "Osteoma," "Angioma," "Glioma," "Hydrocephalus," "Spina Bifida," "Ascites," "Anasarca," "Pleurisy," "Pericarditis," "Endocarditis," "Abortion," "Ectopic Gestation," "Puerperal Convulsions," "Puerperal Septicemia," "Puerperal Eclampsia," "Puerperal Hemorrhage," "Puerperal Fever," "Puerperal Peritonitis," "Puerperal Abscess," "Puerperal Mania," "Puerperal Pyemia," "Puerperal Uremia," "Puerperal Infection," "Puerperal Intoxication," "Puerperal Septic Poisoning," "Puerperal Septic Infection," "Puerperal Septic Intoxication," "Puerperal Gastritis," "Puerperal Enteritis," "Puerperal Gastro-Enteritis," "Puerperal Colitis," "Puerperal Entero-Colitis," "Puerperal Nephritis," "Puerperal Bright's Disease," "Puerperal Peritonitis," "Puerperal Appendicitis," "Puerperal Ulceration of Stomach," "Puerperal Ulceration of Intestines," "Puerperal Stomach Disease," "Puerperal Intestinal Disease," "Puerperal Bowel Disease," "Puerperal Liver Disease," "Puerperal Kidney Disease," "Puerperal Disease of Heart," "Puerperal Valvular Disease of Heart," "Puerperal Brain Disease," "Puerperal Disease of Lungs," "Puerperal Womb Disease," "Puerperal Disease of Bladder," "Puerperal Disease of Prostate Gland," "Puerperal Locomotor Ataxia," "Puerperal Paralysis Agitans," "Puerperal Sclerosis," "Puerperal Cirrhosis," "Puerperal Fatty Degeneration," "Puerperal Obstruction," "Puerperal Duodenal Ulcer," "Puerperal Carcinoma," "Puerperal Sarcoma," "Puerperal Adenoma," "Puerperal Fibroma," "Puerperal Myoma," "Puerperal Neuroma," "Puerperal Papilloma," "Puerperal Epithelioma," "Puerperal Chondroma," "Puerperal Lipoma," "Puerperal Osteoma," "Puerperal Angioma," "Puerperal Glioma," "Puerperal Hydrocephalus," "Puerperal Spina Bifida," "Puerperal Ascites," "Puerperal Anasarca," "Puerperal Pleurisy," "Puerperal Pericarditis," "Puerperal Endocarditis," "Puerperal Abortion," "

Spec.—1-10-21—M&T—1500 Bks.

E 21617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Fait Avenue ST., 1-3 WARD)

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Zimnawoda

(a) RESIDENCE No. 2427 Fait Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna Zimnawoda

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Dundalk

(c) Name of employer Foundry

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs. Anna Zimnawoda, wife. 2427 Fait Avenue

15 Filed 2 5 1927 C. 19 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 27

17

I HEREBY CERTIFY, That I attended deceased from April 19 . 1927 . to April 22, . 19 27 .

that I last saw him alive on April 22 . 19 27 .

and that death occurred, on the date stated above, at 11.30 AM p.m.

The CAUSE OF DEATH* was as follows:

Heatstroke

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Jamrozski M. D.

4/25 1927 (Address) 2481 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetary. DATE OF BURIAL: April 26 19 27

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21618

CERTIFICATE OF DEATH

90 E 21618

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 29 Rosekemp Ave (Laurville) St. 27-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Warick Schumacher

(a) RESIDENCE NO. 29 Rosekemp Ave (Laurville) St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry A.Schumacher

6 DATE OF BIRTH (month, day, and year) July 21, 1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	79	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) New York

(State or country) N.Y.

PARENTS

10 NAME OF FATHER John Warick

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mr John M.Schumacher

(Address) 29 Rosekemp Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 24,1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 19 26, to April 24, 19 27, that I last saw h[illegible] alive on April 6, 19 27, and that death occurred, on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) mos.

CONTRIBUTORY (Secondary) Arteriosclerosis Myocarditis with Fibrillation

(doration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones M. D.

4/25 19 (Address) 708 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetry — Date of Burial: April 26 19 27

20 UNDERTAKER: Jos J Jourdeney + Son — ADDRESS: 217 S. Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPAT[illegible] is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 21619

2023

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 16-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Kines

(a) RESIDENCE NO. 1011 N. Lafayette Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan-31-27

7 AGE — Years: — Months: 2 Days: 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER Clarence Kines

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER Violet Brooks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Record.

(Address): JOHNS HOPKINS HOSPITAL

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24-1927.

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to April 24, 1927, that I last saw h[illegible] alive on April 24, 1927, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Premature.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Intestinal indigestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J P Price

, 19 (Address) Johns Hopkins Hosp. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hortons Farm. Date of Burial: 4-26, 19 27

20 UNDERTAKER a. a. Co. md ADDRESS 1027 N. Howard St

John H. Toadvine

R 26 1927

Reg.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21620

CERTIFICATE OF DEATH

E 21620

1-PLACE OF DEATH

City of BALTIMORE: (No. 832 S. Eutaw St. 21-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Alexander

(a) RESIDENCE NO 832 S. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 3 mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 23-1927

7 AGE — Years: — Months: 3 Days: 2 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant dau

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland.

PARENTS

10 NAME OF FATHER Dorie Alexander

11 BIRTHPLACE OF FATHER (City or town): Hammondsville

(State or country): S. Carolina

12 MAIDEN NAME OF MOTHER Emma Dorier

13 BIRTHPLACE OF MOTHER (city or town): Goodwin

(State or country): S. Carolina

14 Informant: Dorie Alexander

(Address): 832 S Eutaw

15 Filed APR 26 1927

H. HARRISON JONES, M. D. Registrar

Per [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): apr-25 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 19 27, to 4/24, 19 27,

that I last saw her alive on 4/24, 19 27,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

Primary

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? "University Baby Clinic"

(Signed) David Drancis M. D.

4/27, 19 27 (Address) 1220 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: 4-26 1927

20 UNDERTAKER: John H. Trodman — ADDRESS 1027 Hanover St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21621 HEALTH DEPARTMENT—CITY OF BALTIMORE 31

CERTIFICATE OF DEATH.

E 21621

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 745 Little George St (St.) 17-21 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Riley

(a) RESIDENCE NO. 745 Little George St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aretha Riley

6 DATE OF BIRTH (month, day, and year) June 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED Waiter 010

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Paul Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Aretha Riley (Address) 745 Little George St

15 Filed APR 26 1927 C. HAMPTON JONES, Registrar By KH Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1927, to April 23, 1927, that I last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lung

Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lung + Complications

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) J. G. W. Kennard, M. D.

4-25 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Apr 26 1927

20 UNDERTAKER John H. Trader — ADDRESS 1021 Hanover

TION is very important. See instructions on back of certificate.

Spec.--12-9-25--A Co.--200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21622

CERTIFICATE OF DEATH.

129 E 21622

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balty City Hospital (St.) 26-37 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Fosenblin

(a) RESIDENCE NO. Waterville Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant John Steiner

(Address) Waterville Md

15 Filed APR 26 1927 H. HOWARD JONES, M. D.

Per RC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927 to April 22, 1927 that I last saw him alive on April 22 1927 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH was as follows:

Interstitial Cardiovascular Disease Chronic Myocarditis Chronic Pneumonia Nephritis and Thrombosis Right Popliteal (duration) unknown ds.

CONTRIBUTORY (Secondary) Senile Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. Heywood M. D.

, 19 (Address) Balty City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taylorsville Md. Date of Burial Apr 28 1927

20 UNDERTAKER Weer & Son, Inc. ADDRESS Taylorsville Md.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21623

CERTIFICATE OF DEATH.

161-901

E 21623

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 11-24 Ward)

2-FULL NAME Baby Girl Jones

(a) RESIDENCE NO. 1104 Madison Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of =

6 DATE OF BIRTH (month, day, and year) April 23/27

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	0	0	10hrs.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Willie Jones

11 BIRTHPLACE OF FATHER (city or town) ...

(State or country)

12 MAIDEN NAME OF MOTHER Maggie Jones

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSP.

C. HAMILTON JONES, M. D.

15 Filed APR 26 1927 295 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) James H. Connolly, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... Date of Burial ... 19

20 UNDERTAKER ... ADDRESS ...

JOHNS HOPKINS HOSPITAL

Commissioner of Health APR 25 1927

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Zell Bullock

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21624

E 21624

W. CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 Fairmount St. 4-75 Ward)

2-FULL NAME Zell Bullock

(a) RESIDENCE NO. 640 Fairmount St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Div

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 21 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	~~0~~	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Zell Bullock

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Barbados

12 MAIDEN NAME OF MOTHER Martha Cleary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Zell Bullock

(Address) 640 Fairmount Ave.

15 Filed MAR 26 1927 19 K. H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Bronchitis

Broncho Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY

(Secondary)

(duration) 0 yrs. mos. ds.

(Signed) Daniel F. Wisher M. D.

(Coroner)

, 19 27 (Address) 3325 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial April 26 1927

20 UNDERTAKER Dennis Easter ADDRESS 96 E ave.

Be sure to write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dr Ruzecka - 800 Park Place

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21625

CERTIFICATE OF DEATH.

90 E 21625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1817 E 30th St. 9-46 (Ward)

2-FULL NAME Rachel L Rosendorn

(a) RESIDENCE No. 1817 E 30th St, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Rosendorn

6 DATE OF BIRTH (month, day, and year) Oct 8 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER George W. Ramsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary M Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant George Rosendorn (Address) 1817 E 30th St

15 Filed APR 26 1927 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 27 to April 25 1927

that I last saw h[illegible] alive on April 24 1927

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) I. Fred Ruzecka, M. D.

1927 (Address) 800 N Date St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 27 1927
UNDERTAKER	ADDRESS
Pelham Cook	302 E Madison

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21626

CERTIFICATE OF DEATH.

E 21626

1-PLACE OF DEATH

City of BALTIMORE: (No. 1812 N. Fulton Ave St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl A. Gunther

(a) RESIDENCE NO. 1812 N. Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Prudencke Gunther

6 DATE OF BIRTH (month, day, and year) Nov 9, 1864

7 AGE — Years: 62 — Months: 5 — Days: 15 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 088

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Louise A. Gabriel

(Address) 1813 N. Fulton Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.

(Coroner)

April 27 1927 (Address) 502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: 6/11 26 1927

20 UNDERTAKER: H. C. Cook — ADDRESS: 302 E. North Ave

REG 1927 — EDWARD JONES M.

Be sure to print name, address and duty of property, carefully. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21627

101-001

E 21627

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33 & Calvert St.) 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Robert Taylor

(a) RESIDENCE NO. Hotel Belvedere St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Winship Taylor

6 DATE OF BIRTH (month, day, and year) July 27, 1853

7 AGE: Years 73 Months 8 Days 27

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Stock Broker)

(b) General nature of indostry, business, or estabiishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Mr. Talbot Taylor

11 BIRTHPLACE OF FATHER (City or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Louisa Neal

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hosp Record (Address) Union Memorial Hosp

15 Filed APR 26 1927, 19 H. L. JONES M. Registrar Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1927, to April 24, 1927, that I last saw h[illegible] alive on April 24, 1927, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(doration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Hamrick, M. D.

, 19 (Address) Union Memorial Hosp. 33 & Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Apr 28 1927

20 UNDERTAKER: Henry H. Perkins Bro. ADDRESS: 1911 Clifton Ave. Baltimore

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 21628

REGISTERED NO. 13449

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Selina Keighler Smith

(a) RESIDENCE NO. 523 W. 40th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of T. Marshall Smith

6 DATE OF BIRTH (month, day, and year) May 18 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min..
	58	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Keighler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mr T. Marshall Smith

(Address) 523 W. 40th St. Balto

15 Filed ..... 19 C. H. [illegible] N. JONES, M. D. Registrar

Per R.J.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 25, 1927, that I last saw h.s alive on April 25, 1927, and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Glioma - Brain

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 15 1926

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Alan Hunter, M. D.

, 19 (Address) Union Mem Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas. Cem Garrison Blvd — Date of Burial 4-27 1927

20 UNDERTAKER Henry W. Jenkins Sons Co. — ADDRESS Orchard & McCulloh

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 21629

CERTIFICATE OF DEATH.

E 21629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 W. Biddle ST. 11-24 WARD)

2-FULL NAME Sara Linton Ross

(a) RESIDENCE NO. 50 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Judge Nathan Ross

6 DATE OF BIRTH (month, day, and year) July 24, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buck's Co. Pennsylvania

PARENTS

10 NAME OF FATHER Amos Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Josie Ross Pancoast

(Address) 50 West Biddle Street

15 Filed APR 26 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RHC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17

I HEREBY CERTIFY, That I attended deceased from April 2nd, 1927. to April 24th, 1927. that I last saw her alive on April 24th, 1927. and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, left lobar

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Omar B Pancoast, M. D.

, 19 (Address) 50 West Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friend's Burial Ground

DATE OF BURIAL 4/26 1927

UNDERTAKER Henry W. Bears & Son

ADDRESS 803 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21630 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21630

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Caroline St. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Garfinkel

(a) RESIDENCE NO. 206 S. Caroline St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Garfinkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Cohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Garfinkel

(Address) 206 S Caroline St

15 Filed APR 26 1927 H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1927, to Apr 26 1927, that I last saw h— alive on Apr 25 1927 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis (Left femur, lungs, spine, Brain etc)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Dec 26

Was there an autopsy? No

What test confirmed diagnosis? Exploring L femur

(Signed) A. F. Ries, M. D.

Apr 26 1927 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 4/28 1927

20 UNDERTAKER Jack Levin 709 E Balto St

ADDRESS

'TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21631 HEALTH DEPARTMENT—CITY OF BALTIMORE 74001 E 21631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N Stricker St 14-27 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alice Butler

(a) RESIDENCE NO. 514 N Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Henry Butler

6 DATE OF BIRTH (month, day, and year) March 26-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
57	4	—	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md

PARENTS

10 NAME OF FATHER John Shearin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Evelina Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mildred E Jordan
(Address) 514 N Stricker St

Filed ... 19... G. HAYDEN JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 1st, 1927, to Apl 23, 1927, that I last saw her alive on Apl 23, 1927, and that death occurred, on the date stated above, at 11.02 P m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Hypertonic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 856 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Unity Montgo Co Md — DATE OF BURIAL 4-26 1927

20 UNDERTAKER Geo R Snowden — ADDRESS Rockville Md

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21632

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 21632

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2506 Raynor Av St. 16 68 Ward)

2-FULL NAME Joseph Cephas

(a) RESIDENCE NO. 2506 Raynor Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Cephas

6 DATE OF BIRTH (month, day, and year) about 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Cephas

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Georgiana King

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Gary Cephas

(Address) 2506 Raynor Ave.

Filed APR 28 1927 19 C. Evans Jones Registrar.

Per H R

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

April 23 192 7 (Address) 2502 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial April 26/1927

20 UNDERTAKER Daniel Easton ADDRESS Cem

OF DEATH in pencil only, as that is only as properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21633

E 21633

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Walbrook Ave. & Edgewood ST. 15-67 WARD)

2-FULL NAME Margaret F. Tippett

(a) RESIDENCE NO. Walbrook Ave. & Edgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard B. Tippett

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Thornton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Richard B. Tippett
(Address) Walbrook Ave. & Edgewood St.

15 Filed APR 26 1927, 19 E. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/27 19

17

I HEREBY CERTIFY, That I attended deceased from Jan'y 27, 19 to Apr 24, 1927.

that I last saw her alive on Apr 24, 1927

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage and paralysis — arterio-sclerosis — myocarditis about 4 yrs.

(duration)

CONTRIBUTORY (Secondary) Hypo-static pneumonia & Edema of lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter Wilbert, M. D.

19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/27, 19 27

20 UNDERTAKER Henry H. Mears & Son ADDRESS 623 N. Calvert

TION IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21634

CERTIFICATE OF DEATH.

E 21634

REGISTERED NO.

1-PLACE OF DEATH (In garage in the rear 28-63 74001

City of BALTIMORE: (No. 4022 Woodbine Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Jos. McKenna

(a) RESIDENCE NO. 4022 Woodbine Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M. McKenna

6 DATE OF BIRTH (month, day, and year) June 8-1879

7 AGE: Years 47 Months 10 Days 16 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumbing Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 059

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Daniel McKenna

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Ryan

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant (Address): Mrs. Florence M. McKenna 4022 Woodbine Ave

15 Filed ... 1927 ... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ....yrs. ....mos. ....ds.

(Signed) E. L. Kennedy M. D. (Coroner)

1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Apl 27 1927

20 UNDERTAKER: Putnam & Gore ADDRESS 1723 W. Lafayette Ave

Of the 11 items, only the first seven, as to letter, are necessary to complete the certificate. The remaining items are very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21635

CERTIFICATE OF DEATH.

E 21635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH M Hospital

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

2-FULL NAME Emma Richardson

(a) RESIDENCE NO. 827 McKim St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Patsy Ranger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) W. Richardson 833 McKim St.

15 Filed APR 26 1927 H. Wade Hall JONES, M. D. Registrar Per K/K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927 to April 24, 1927

that I last saw h[illegible] alive on April 24, 1927

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 20-27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L Smeltz, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlottesville Va DATE OF BURIAL April 26 1927

20 UNDERTAKER Edward Bonjon ADDRESS 631 Orleans St

HOW IS very important. See instruction on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Hardy G. Cockerell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21636 + 56-001 E 21636

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hardy G Cockerell

(a) RESIDENCE NO. Rocky Mount, N.C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lula Cockerell

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work farmer Off

(b) General nature of industry, business, or establishment in which employed (or employer) farmer

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Geo Cockerell

11 BIRTHPLACE OF FATHER (city or town) No. Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Bottoms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Carolina

14 Informant Hardy G. Cockerell.
(Address) JOHNS HOPKINS HOSPIT

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
April 25, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to April 25, 1927, that I last saw h.... alive on April 25, and that death occurred, on the date stated above, at 7 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Hemolytic Anemia, Acquired
(Acquired Hemolytic Jaundice.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative pneumonia and pericarditis (duration) ? yrs. ? mos. 3 ds.

18 Where was disease contracted
If not at place of death? Not known

Did an operation precede death? yes Date of April 19, 1927

Was there an autopsy? No

What test confirmed diagnosis? Fragility test of erythrocytes

(Signed) Warfield M. Firor, M. D.

, 19 (Address) 1148

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rocky Mount N C — Date of Burial 4/26/1927

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

2 S 1927

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21637

CERTIFICATE OF DEATH

129

E 21637

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Esplanade Apts. 4 E. St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Kayton Gutman

(a) RESIDENCE NO. Esplanade Apts. 4 E. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida N. Gutman

6 DATE OF BIRTH (month, day, and year) May 3rd. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	66	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept. Store Prop.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Joel Gutman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Kayton

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mr. Joel Gutman

(Address) Pierce Ave.

15 Filed 26 1927 C. HAMILTON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1927, to April 26, 1927, that I last saw him alive on April 25, 1927, and that death occurred, on the date stated above, at 8 15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? None Date of 2 years ago

Was there an autopsy? No prostatectomy

What test confirmed diagnosis?

(Signed) Julius Friedenwald, M. D.

. 19 (Address) 1013 N. Charles St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Hebrew Cem.

Date of Burial 4/28/1927

20 UNDERTAKER Aaird Sondheim

ADDRESS N. 20 W. Mt. Royal Ave.

Spec.–7-17-26—A Co.—200 Bks.

Hargo Hopkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21638

CERTIFICATE OF DEATH

REGISTERED NO. E 21638

1-PLACE OF DEATH

City of BALTIMORE: (No. 1218 Whatcoat St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Hopkins

(a) RESIDENCE NO. 1218 Whatcoat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	45	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Mrs. Harding

(Address) 1218 Whatcoat St.

15 Filed C. HOWARD JONES, M. D.

Registrar

Dep.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-1927

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1927, to 4-24, 1927, that I last saw him alive on 4-24, 1927, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exposure + Low vitality

(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank A. Saunders, M. D.

, 19 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Va Date of Burial April 26/27

20 UNDERTAKER Dennis Carson ADDRESS Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 26 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 21639

E 21639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1302 Madison Ave St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Laura St. Clair

(a) RESIDENCE NO. 1302 Madison Ave St._____ Ward Non Resident

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 24 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Chas. St. Clair

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Stella ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant E A Gibson
(Address) 1302 Madison Ave

15 Filed APR 26 1927 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ___ yrs. ___ mos. 14 ds.

CONTRIBUTORY (Secondary) no other history

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

April, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wetherille Va — Date of Burial April 28 1927

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa Ave

Cut on dotted line and deliver to undertaker. Certificate of Death in part form, so that it may be properly classified. Fill out statement of occupation as it is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21640

CERTIFICATE OF DEATH.

74-001
74 E 21640

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 N Arlington Ave ST. 18-16 WARD)

2-FULL NAME Susan M Brown

(a) RESIDENCE NO. 313 N. Arlington Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Brown

6 DATE OF BIRTH (month, day, and year) June 12th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Himmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Zapfle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ludie Baumgartner
(Address) 326 E. Lanvale St

15 Filed 4/26 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927 to April 24, 1927 that I last saw her alive on April 23, 1927 and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination + Symptoms

(Signed) Edward Eschenmeyer M. D.

4/25 1927 (Address) 1339 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Apr 27 27

20 UNDERTAKER Ulman Corp'l — ADDRESS 502 E Lanvale Av

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21641

E 21641

CERTIFICATE OF DEATH.

REGISTERED NO. 16108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Mc Elderry St., 7-9 WARD)

2-FULL NAME Baby Bowden

(a) RESIDENCE NO. 412 N. McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 min. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/24/27

7 AGE Years Months Days If LESS than 1 day hrs. 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Clinton Bowden

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Frances Jones

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Frances Bowden mother (Address) 412 N. McElderry St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1927, to April 24, 1927, that I last saw him alive on April 24, 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis of Lung 45 mins. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth (8 mos) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young M. D.

4/24, 19 27 (Address) 412 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. BRANSON JONES, M. D. Commissioner of Health

APR 25 192

APR 26 1927 1209

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21642

CERTIFICATE OF DEATH.

3 | E 21642

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals St. (1427) Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Terry

(a) RESIDENCE NO. 1527 W. Fairmount ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1301 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927 to April 23, 1927, that I last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Gatting, M. D.

4-23-27 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial APR 26 1927 19

20 UNDERTAKER ADDRESS

Commissioner Health

UNIVERSITY OF MARYLAND

Per R. S. [illegible]

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21643.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 E 21643

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 76-37 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Miller

(a) RESIDENCE NO. _____ St. _____ Ward _____

(Usual place of abode) BALTIMORE CITY HOSPITALS

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE: Years 72 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Georgiana Dimcly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Cor. Records

15 Filed _____ 19____ CHAS. H. JONES, M. D. Registrar

1342 APR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 22, 1927, that I last saw him alive on April 22, 1927, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis

(duration) ? yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ___ yrs. ___ mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ___

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hodges Smith, M. D.

April 23 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ___ Date of Burial APR 25 1927 19___

20 UNDERTAKER ___ ADDRESS ___

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21644

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21644

CERTIFICATE OF DEATH.

17015 / 16002

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 27-43 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gracey

(a) RESIDENCE NO. 29 Forest ave - Catonsville St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 21, 1927

7 AGE: Years | Months | Days | IF LESS than 1 day 14 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nil

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER John F. Gracey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Pricket

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Records

(Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... Registrar

1306 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1927, to 4-21, 1927, that I last saw he alive on 4-21, 1927 and that death occurred, on the date stated above, at 3-15 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Difficult labor —

Breech extraction (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 4/21/27

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. R. Hoerner, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial: Dec 26 1927 19

20 UNDERTAKER: Commissioner of Health. ADDRESS

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21645

CERTIFICATE OF DEATH.

161-001

E 21645

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St., 7-4 Ward)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. Joppa Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22, 1927

7 AGE: Years ___ Months ___ Days ___ IF LESS than 1 day 32 hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ND

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles E. Simmons

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Hattie Smith

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant Records

(Address) Johns Hopkins Hospital.

15 C. HAMPTON JONES, M. D.

Registrar

6 1927 Per 1307

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4-22, 1927, to 4-22, 1927

that I last saw her alive on 4-22, 1927

and that death occurred, on the date stated above, at 12 08 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Pneumonia (lobar)

in mother (duration) ___ yrs. ___ mos. 3 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial APR 25 19 27

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Baltimore City Health Department

Bureau of Records

Certificate of Death

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 21646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Ryan (ST.) 21-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Burns

(a) RESIDENCE NO. 911 Ryan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie L Burns

6 DATE OF BIRTH (month, day, and year) May 17 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bridget Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Annie L Burns (Address) 911 Ryan St

15 Filed 6 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/3 1927, to 4/23 1927, that I last saw him alive on 4/23/27 6.30 P. m. and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cystoma Liver

Hyperplasia Cirrhosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Bernard J. Fenn, M. D.

4/25/27 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem. DATE OF BURIAL 4/27 1927

20 UNDERTAKER John J Conway & Son (Per) J. J. Conway ADDRESS 901 Hollins St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21647

CERTIFICATE OF DEATH.

44 E 21647

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 S. 13th St. St. 76-37 Ward

2-FULL NAME Barbara Bandy

(a) RESIDENCE NO. 312 S. 13th St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Bandy.

6 DATE OF BIRTH (month, day, and year) Aug 15-1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Vobralek

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Austria

14 Informant Albert Bandy. (Son)

(Address) 360x Eden or Gay

C. HAMILTON JONES, M. D.

15 Filed 1927 Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to April 24, 1927, that I last saw h-er alive on April 24, 1927, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None other

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 17-1926

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. L. Long, M. D.

4/29 1927 (Address) 1701 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Apr. 27 1927

20 UNDERTAKER Tilly & Julia ADDRESS 403 S. Wolfe St.

26 1927

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21648

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S. Ellwood ave St. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada E. Payne.

(a) RESIDENCE NO. 235 S. Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank L. Payne

6 DATE OF BIRTH (month, day, and year): March 8-1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Edw. A. Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Regina Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Frank L. Payne

(Address): 235 S. Ellwood ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to April 26, 1927.

that I last saw her alive on April 25, 1927

and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Metastases

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?: unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tillow M. D

4/26, 1927 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury; and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn. Cemetery

DATE OF BURIAL: April 28 1927

20 UNDERTAKER: Zirkler + Zirkler

ADDRESS: 1739-E Eager

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21649 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 S. Highland Ave ST. (WARD) 26-2

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Dr. David Hughes

(a) RESIDENCE NO. 321 S. Highland Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Hughes.

6 DATE OF BIRTH (month, day, and year) May 4 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman 018

(b) General nature of industry, business, or establishment in which employed (or employer) Abbott Memorial Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Edwd Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Howard Hiltz

(Address) 3514 Bank St.

15 Filed 1927 C. HAMPSON JONES, M. D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1927, to Apr. 24, 1927, that I last saw him alive on April 24, 1927 and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Frank A. Hanty, M. D.

4/26, 1927 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL April 27 1927

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E Lyon

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21650

CERTIFICATE OF DEATH.

89

REGISTERED NO. E 21650

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 Dawson St. Ward 22 30)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Palmer

(a) RESIDENCE NO. 604 Dawson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Palmer

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 49-50 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturing

(c) Name of employer: County

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Unknown Palmer

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown Scott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Mary Palmer

(Address): 604 Dawson St

15 Filed 2-7 1927 C. HAMILTON JONES, M. D. Registrar

Per R.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Daniel O'Connor M. D.

(Coroner)

, 19 2 (Address) 3323 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Richmond Va Date of Burial: Jan 29 1927

20 UNDERTAKER: J. H. Brown & Son ADDRESS: 1080 Madison

If very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

E 21651

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21651

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 823 W. Lexington St. 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Marie Roan

(a) RESIDENCE NO. 823 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 26-1927

7 AGE: Years 1 Months 0 Days 29

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nv

(b) General nature of industry, bnsiness, or establishment in which emploved (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto City

PARENTS

10 NAME OF FATHER David Roan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Howden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant David Roan

(Address) 823 W Lexington St

15 Filed APR 27 1927 G. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24 1927 to April 25 1927

that I last saw him alive on April 25 1927

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mes. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/25 1927 (Address) 1225 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: April 27/1927

20 UNDERTAKER: Daniel Easton — ADDRESS: 916 Park Ave

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 21652

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21652

CERTIFICATE OF DEATH

11-001

1-PLACE OF DEATH

REGISTERED NO. 4433

City of BALTIMORE: (No. 1015 William St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Lindemann

(a) RESIDENCE NO. 1015 William St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 0 mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George N A Lindemann

6 DATE OF BIRTH (month, day, and year) April 20, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	71	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Edw. Vollerdt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant George N Lindemann

(Address) 1015 William St.

15 Filed APR 27 1927 19 C. HAMILTON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 25, 1927,

that I last saw h alive on April 25, 1927,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Mitchell M. D.

4/26, 1927 (Address) 1271 Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial April 28 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

If DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21653

CERTIFICATE OF DEATH.

196 E 21653

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 E Pratt St 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer S Stehman

(a) RESIDENCE NO. 1801 St Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 2. 1892

7 AGE — Years: 35 Months: 1 Days: 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrical Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): 029

(c) Name of employer: Keystone Electric Co

9 BIRTHPLACE (city or town)

(State or country): Pa

PARENTS

10 NAME OF FATHER: Abraham Stehman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Emma Stach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant: Howard Leber (Columbia Pa)

(Address) 801 Locust St (Columbia Pa)

15 Filed APR 27 1927 19 C. H. [illegible] Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted by coming in contact with live wires of 108 E. Pratt

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Burns

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

(Coroner)

Apr 27 1927 (Address) 1137 Bayard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia, Pa, Date of Burial: Apr 29 1927

20 UNDERTAKER: H. A. Cook ADDRESS 302 E Market

To Hampton

Please write plainly, and use only black or purple ink. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21654 E 21654

X 188-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at the

City of BALTIMORE: (No. South Baltimore General H[illegible] St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna G. Davies.

(a) RESIDENCE NO. English Consul, Balto. Co. Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. few hours mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 22, 1922

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Harold Davies.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wales.

12 MAIDEN NAME OF MOTHER Helen Sheckells.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Helen Davies. (mother)

(Address) Lansdowne P.O. Balto. Co. Md.

15 Filed APR 27 1927, 19 C. HAMILTON JONES, M. D.

Per K K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, jaw & humurus.
Struck and knocked down by an automobile
Occidental death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inquest held in Balto. Co

(duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

4/26 19 27 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Annapolis Rd. English Consul Balto. Co. Md.

Former or usual residence April 24, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial Apr 27 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificate.

If the exact statement of OCCUPATION is properly classified. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1549 E 21655

CERTIFICATE OF DEATH.

E 21655

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. Church Home Infirmary St. 5-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Loy Wilson

(a) RESIDENCE NO. 2125 N. Smallwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt. Maryland.

PARENTS

10 NAME OF FATHER Lee Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) W. Daniel Maryland.

12 MAIDEN NAME OF MOTHER Marie Jackson.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Tolchester Maryland.

14 Informant Church Home & Infirmary

(Address) Baltimore

15 Filed APR 27 1927 C. HAMILTON JONES, M. D. Registrar

Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1927.

17

I HEREBY CERTIFY, That I attended deceased from April 22 1927, to April 26, 1927, that I last saw him alive on April 26, 1927, and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Stenosis of Pulmonary Valve and Artery

Myocardial fibrosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Congenital Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Murray well S. Edelson, M. D.

, 19 (Address) Church Home Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tolchester Island Date of Burial April 27 1927

20 UNDERTAKER Josiah Leffler ADDRESS 1600 N. North Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21656

CERTIFICATE OF DEATH.

112

E 21656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 E. Barney ST. 24-34 WARD)

2-FULL NAME Henry Martin Lucas Jr.

(a) RESIDENCE NO. 114 E. Barney ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 3-18-1927

7 AGE: Years — Months: 1 — Days: 8 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: H. M. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Kathain Jay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Lucas

(Address) 114 E Barney

15 Filed: R27 1927 By: R.H. Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-25 1927

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to April 25, 1927,

that I last saw h alive on April 25, 1927

and that death occurred, on the date stated above, at 1 10 P.M.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ephemeritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 4/27 1927

20 UNDERTAKER: J. F. McCully

ADDRESS 130 E. Front.

Spec.—1-10-21—M&T—1500 Blks.

E 21657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hosp

CITY OF BALTIMORE: (No. 28-64 ST. WARD)

2-FULL NAME Robert Wheeler

(a) RESIDENCE NO. 4304 Kathland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. R. Wheeler

6 DATE OF BIRTH (month, day, and year) Oct 31, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm J. Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda E. Spelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hospital Record.

15 APR 27 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to April 26, 1927, that I last saw him alive on April 26, 1927, and that death occurred, on the date stated above, at 12 45 Am.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 10? ds.

Contributory (Secondary) Pneumonia

(duration) yrs. mos. 5? ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of April 25, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem — DATE OF BURIAL 4/29 1927

20 UNDERTAKER L. F. McCully — ADDRESS 130 S. Front

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Gunnell

HEALTH DEPARTMENT—CITY OF BALTIMORE

51

E 21658 903

CERTIFICATE OF DEATH.

REGISTERED NO. E 21658

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT St. 7069 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ilsie Gunnell

(a) RESIDENCE NO. 2730 Kinsey Ave St. City Ward

2730 N Ballo St.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29, 1918

7 AGE: Years 8 Months 8 Days 27 IF LESS than 1 day ..... hrs. or ..... min. 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country)

PARENTS

10 NAME OF FATHER Albert Gunnell

11 BIRTHPLACE OF FATHER (city or town) Pa -

(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Sypff -

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant Reeds -

(Address) JOHNS HOPKINS HOSPT

Filed APR 27 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1927, to April 25, 1927, that I last saw her alive on April 25, 1927, And that death occurred, on the date stated above, at 8 0- m.

The CAUSE OF DEATH* was as follows:

Rheumatic fever, acute

Rheumatic cardiac disease

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: April 28, 1927

20 UNDERTAKER: E. LeRoy Staffler — ADDRESS: 1256 E Monument

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21659

CERTIFICATE OF DEATH.

E 21659

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Widners Stables (St.) Rear (Ward) 90

2-FULL NAME Henry K. Keese

(a) RESIDENCE No. 7322 Reynolds St. Philadelphia Pa. Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie R. Keese

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Horse Rubber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J. H. Widners.

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hattie R. Keese (Address) Philadelphia Pa.

15 Filed ... 192 ... Registrar

R 27 1927 C. HARRISON JONES, M. D.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) John J. Morrison, M. D.
(Coroner.)

4/26, 1927 (Address) 1632 Rutland Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	April 27, 1927
20 UNDERTAKER E. LeRoy Stiffler	ADDRESS 125 E. Rolla Ave

Burkom.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 21660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21660

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 E. Pratt ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice A. Burkom

(a) RESIDENCE. NO. 1827 E. Pratt ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Burkom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Charapow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Burkom (Address) 1827 E. Pratt St.

15 Filed APR 27 1927 19 C. HARRISON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27. 1927

17 I HEREBY CERTIFY, That I attended deceased from August 19 26. to April 27. 19 27.

that I last saw him alive on April 26 19 27.

and that death occurred, on the date stated above, at 6 50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocardial Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil F. Zeugler, M. D.

4/27 1927 (Address) 1960 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hevria Cem	4-27- 1927

20 UNDERTAKER Jack Levin, ADDRESS 1429 E Balto St

THIS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21661

CERTIFICATE OF DEATH

E 21661

REGISTERED NO. 27-47

1-PLACE OF DEATH

City of BALTIMORE: (No. 45 Woodlea Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Friedel

(a) RESIDENCE NO. 45 Woodlea St. Gardenville Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Friedel

6 DATE OF BIRTH (month, day, and year) May 23rd 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	41	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John M. Friedel

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Bunge

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Isabella Friedel Wife

(Address) 45 Woodlea Gardenville

15 Filed APR 27 1927 Per

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 26, 1927, that I last saw him alive on April 26, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Horace M. Tolson, M. D.

(Address) 815 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial 4/29/27

20 UNDERTAKER Lilly & Zeller — ADDRESS 1038 E. Monument St

IF DEATH IS FROM VIOLENCE, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21662

CERTIFICATE OF DEATH.

60-001

E 21662

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hazel E Moore
Last address

(a) RESIDENCE NO. 6317 Calhoun St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	27	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robert E L Mullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Cora Clapdore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs James H. Weems
(Address) 102 Melvin Ave Catonsville

15 Filed APR 27 1927 Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1927.

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927. to Apr. 26, 1927
that I last saw her alive on Apr 26, 1927
and that death occurred, on the date stated above, at 10 35A m.

The CAUSE OF DEATH* was as follows:

Exophthalmus. Goitre

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Operation & predisposing

Did an operation precede death? Yes Date of Apr 26-27

Was there an autopsy? Yes

What test confirmed diagnosis Autopsy & op.

(Signed) E K Miller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 29 1927

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 ✓

E 21663

CERTIFICATE OF DEATH.

E 21663

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Blumenthal

(a) RESIDENCE NO. 1001 E. Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Louis Blumenthal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bell Seidel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant David Blumenthal

(Address) 2026 E. Pratt St

15 Filed ..... 19 ..... Registrar

(HAND STONES, M. D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Tuesday April 26

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to April 26, 1927

that I last saw him alive on April 26, 1927

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

1 Ruptured Intestine

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY General Peritonitis

(Secondary)

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of April 26 1927

Was there an autopsy? No

What test confirmed diagnosis? Exploratory after clinical sign and symptom

(Signed) C. Hyman, M. D.

4/26 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run Date of Burial 4/27 1927

20 UNDERTAKER S. Feinman Sec E. Baltimore ADDRESS 1127

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21664

CERTIFICATE OF DEATH.

90 E 21664

REGISTERED NO

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 Canal St. 1124 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Burris

(a) RESIDENCE NO. 330 Canal — ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Burris

6 DATE OF BIRTH (month, day, and year): Nov. 17th 1867

7 AGE: 59 Years 60 Months 5 Days 8 If LESS than 1 day, hrs. or min. 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer, Home work 641

9 BIRTHPLACE (city or town) (State or country): Maryland —

PARENTS

10 NAME OF FATHER: Thomas Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland —

12 MAIDEN NAME OF MOTHER: Ann Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland —

14 Informant: Lola Gwendolyn King

(Address) 705 N. Caroline St.

15 Filed APR 27 1927, 19 C. HAMILTON JONES, M. D. Registrar

Rec'r K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to April 24, 1927, that I last saw her alive on April 24, 1927, and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A. Bani, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: Apr. 27 1927

20 UNDERTAKER: Mrs. R.A. Elliott

ADDRESS: 1725 Eutaw

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21665

CERTIFICATE OF DEATH.

E 21665

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Saina Hospital St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Goldstein

(a) RESIDENCE NO. 2914 Norfolk Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Goldstein

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unkown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Miss Kate Goldstein

(Address) 2914 Norfolk Ave

15 Date APR 27 1927 H. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. H. Jones, M. D.

(Coroner)

4/27/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem Date of Burial 4/27 19

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

IF DEATH IN PRISON, ASYLUM OR POORHOUSE, LAST RESIDENCE OF DECEASED IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21666

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. E 21566

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercey Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Scherr

(a) RESIDENCE NO. 215 N High St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Scherr

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Scherr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Mary Scherr

(Address) 215 N. High St

15 Filed..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed M. D.

(Coroner)

, 192 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale Cem — Date of Burial: April 27 19

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E BaltimOre St

Be sure that PLACE OF DEATH is plainly stated, and that every blank is properly filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

202378 mad

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21667

CERTIFICATE OF DEATH.

X 100-001 E 21667

1-PLACE OF DEATH

City of BALTIMORE: (~~JOHNS HOPKINS HOSP~~ St., 7-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Gordon Templeton

(a) RESIDENCE NO. Mexia, Texas St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Templeton

6 DATE OF BIRTH (month, day, and year) Nov 7, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	5	21	20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Texas

PARENTS

10 NAME OF FATHER J. A. Templeton

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Texas

12 MAIDEN NAME OF MOTHER May E. Harrison

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Texas

14 Informant Records

(Address) JOHNS HOPKINS HOSP

15 Filed APR 27 1927 19 C. HARRISON JONES Registrar M. D.

Per RRS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1927, to Apr. 27, 1927, that I last saw h~~im~~ alive on April 27, 1927, and that death occurred, on the date stated above, at 4:55 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) 3 (History) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Empyema (5 days)

(duration) 10 (History) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of_____

Was there an autopsy? yes.

What test confirmed diagnosis? laboratory

(Signed) W. Lingsay Miller, M. D.

4/27 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Worth, Texas Date of Burial April 27, 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw St.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21668

CERTIFICATE OF DEATH.

98 E 21668
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP'L S. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stull

(a) RESIDENCE NO. 720 Whitridge Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General natnre of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Ehtrud Stull

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elsie Schmitt

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSP

15 Filed 19 R. H. [illegible] M. D. Registrar

APR 27 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to April 26, 1927, that I last saw alive on April 26, 1927, and that death occurred, on the date stated above, at 8 28 a-m.

The CAUSE OF DEATH* was as follows:

Laryngitis (streptococcus)

(duration) yrs. mos. 20(?) ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Home

Did an operation precede death? Tracheotomy Date of Apr. 24, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Cultures

(Signed) J. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cemetery Apr 27 1927

20 UNDERTAKER — ADDRESS

Lilly & Geiser 403 S. Wolfe St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 10-003 E 21669

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital 9-45 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clementine Polek

(a) RESIDENCE NO. 46th St. - Harbor View ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Non Resident (1) yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER Louis Polek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Kokosek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Louis Polek

(Address) Harbor View

15 Filed APR 7 1927 C. HARRY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to April 26, 1927, that I last saw h[illegible] alive on April 26, 1927, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar - Pharyngeal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pos. Cult -

(Signed) Myron G. Tull M. D.

4/27 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

DATE OF BURIAL April 27 1927

20 UNDERTAKER John McAleer

ADDRESS 1803 Bond Street.

TION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 21670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21670
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 W. Saratoga St. ST. 18-76 WARD)

2-FULL NAME Charles Fedderman

(a) RESIDENCE No. 917 W. Saratoga St ST., WARD Cambridge Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Priscilla Fedderman

6 DATE OF BIRTH (month, day, and year) Mar. 3, 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Gertrude Cornick
(Address) 917 W. Saratoga St

15 Filed APR 27 1927 H. HAMPTON JONES, M. D. Registrar
BY [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927 to April 26, 1927, that I last saw him alive on April 26, 1927, and that death occurred, on the date stated above, at 10.10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
with st Hemiplegia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Cambridge Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) J. G. W. Bernard M. D.

4-26 1927 (Address) 708 Emerson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Md. DATE OF BURIAL April 27 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 32½ N. Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21671 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 21671 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Gwynn Oak Ave., ST. 28-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Louis Sander

(a) RESIDENCE NO. 2901 Gwynn Oak Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Blanche Malone Sander

6 DATE OF BIRTH (month, day, and year) Jan. 20. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Sander

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Trapman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Blanche Malone Sander (Address) 2901 Gwynn Oak Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/24/27, 19 , to 4/25/27, 19 , that I last saw h-m alive on 4/25/27, 19 , and that death occurred, on the date stated above, at 10 35 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - + paralysis - Arteriosclerosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema 3 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Hublett, M. D.

(Address) 2220 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL April 28 1927

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21672

CERTIFICATE OF DEATH.

X 45 E 21672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mer Baltimore Gen. Hosp. St. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esau Armstrong

(a) RESIDENCE NO. Cardiff - Wales ST., ... WARD British Isles

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman & trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: S.S. Oxonian

9 BIRTHPLACE (city or town) (State or country): Cardiff, Wales England

PARENTS

10 NAME OF FATHER: Thos Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bath Wales

12 MAIDEN NAME OF MOTHER: Catherine Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant: U.B. Gen. Hosp. Records.

(Address) Rayner Avenue

15 Filed APR 27 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/3, 1926, to 4/26, 1927, that I last saw h[illegible] alive on 4/26, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Appendix.

(duration) yrs. 6 mos 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 15 min. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/1/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Amos L. Jones, M. D.

4/27, 1927 (Address) Mer Bal Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Apr. 28, 1927

UNDERTAKER: [illegible] Cook

ADDRESS: 603 Mulberry St

Cor.—12-9-25—A Co.—200 Bks.

E 21673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21673

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 Hillen St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Ferrara

(a) RESIDENCE NO. 1023 Hillen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Ferrara

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Ferrara

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Mulluso

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Italy

14 Informant Minnie Ferrara

(Address)

APR 27 1927

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 26/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

4/27/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: Feb 5 1927

20 UNDERTAKER: Frank Erickson ADDRESS: [illegible]

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.F.S.—400 Eks.

E 21674 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 101-001

City of BALTIMORE: (No. 634 N Franklin St., 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank Orbino

(a) Residence No. 634 N Franklin St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 21 1925

7-AGE. 1 yrs. 8 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Salvatore Orbino

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Josephine Buriglino

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-

(Informant) Frank Orbino

(Address) 634 N Franklin

15-

Filed 1927 C. [illegible] JONES, M. D. Registrar.

Per RRH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-26-27

17- I HEREBY CERTIFY, That I attended deceased from 4-14, 1927 to 4-26, 1927

that I last saw him alive on 4-26, 1927

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows

Acute Lobar pneumonia

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. mos. 13 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. J. Demarco, M. D.

4-27, 1927 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL. April 28, 1927

20-UNDERTAKER. W M Rouken

ADDRESS 2238 N Arch

Instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21675

CERTIFICATE OF DEATH.

E 21675

1-PLACE OF DEATH South Bath Hospital

REGISTERED NO. 159-002

City of BALTIMORE: (No. 1213 S. Light St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Lee Orndorff

(a) RESIDENCE NO. 305 Hutchings Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 28, 1927

7 AGE: Years | Months | Days: 21 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baltimore

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country): (Virginia)

PARENTS

10 NAME OF FATHER: Gerald Lee

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Rene Keller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Virginia

14 Informant: Gerald Orndorff

(Address) 305 Hutchings Ave

7 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 19 27, to April 27, 19 27, that I last saw h[im] alive on April 27, 19 27, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. Miller, M. D.

, 19 (Address) South Balt. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tombrook Va

Date of Burial: 4/27 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21676 ✓ 90 E 21676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St., 4-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Butler

(a) RESIDENCE NO. 600 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
66	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 BALTIMORE CITY HOSPITALS

Informant

(Address) Records

7 1927 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Novembr 8 1926, to April 22, 1927, that I last saw him alive on April 21, 1927, and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hampson Smith, M. D.

April 25 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Date of Burial 4/28/27

20 UNDERTAKER J. J. Fahey Sons ADDRESS 1316 Eight St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

See letter on file by Dr. Gattens April 29/27

E 21677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21677

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (or B. or Ward) 426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Julia Thomas~~ (Irene Smith) Irene James

(a) RESIDENCE NO. 706 Fairmount ave. W. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Massachusetts

PARENTS

10 NAME OF FATHER Charles Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Hattie Bryan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington, D.C.

14 Informant Hospital Records

(Address)

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from February 28 19 27, to April 20, 1927,

that I last saw h.er alive on April 20, 1927,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pericarditis
Pulmonary tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gattens M. D.

4-26-1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1864 Mary

20 UNDERTAKER Washington Funeral Co. ADDRESS 1927

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21678

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bal. Gen. Hosp. REGISTERED NO. 7564 1 | 39

CITY OF BALTIMORE: (No. ... ST. ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ora T. Small

(a) RESIDENCE—No. 3110 Guyon Oak Ave. ST. ... WARD ... Balto. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. R. Small

6 DATE OF BIRTH (month, day, and year) Nov 30-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co. Md

PARENTS

10 NAME OF FATHER Samuel Leggett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Ora T Small
(Address) 3110 Guyon Oak Ave

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-12, 1927, to 4-27, 1927, that I last saw her alive on 4-7, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(Duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-14-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. A. Reynolds M. D.

4/27/27 (Address) 1111 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gaithersburg Mont Co Md DATE OF BURIAL Apl 29th 1927

20 UNDERTAKER Bertram Gore ADDRESS 1723 N. Fay ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21679 E 21679

CERTIFICATE OF DEATH.

129

15-61

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3226 Elgin Ave. (ST.) 1 (WARD)

2-FULL NAME Mary Virginia Mentzel

(a) RESIDENCE NO. 3226 Elgin Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Lawrence Mentzel

6 DATE OF BIRTH (month, day, and year) Jan 27- 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
73	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) maryland.

PARENTS

10 NAME OF FATHER Alfred Borguet.

11 BIRTHPLACE OF FATHER (city or town) Belg. (State or country) maryland.

12 MAIDEN NAME OF MOTHER Catherine Grimet

13 BIRTHPLACE OF MOTHER (city or town) Belg. (State or country) Md.

14 Informant Walter Mentzel (Address) 3226 Elgin ave.

15 4 27 1927 C. HAMPSON JONES, M. D. Registrar Per RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9- 1927 to Apr. 25 1927

that I last saw her alive on Apr. 25 1927

and that death occurred, on the date stated above, at 1.A. m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Jane Brown, M. D.

4/25 1927 (Address) 1837 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL April 27 1927

20 UNDERTAKER Jos Jourdens & Son — ADDRESS 27 S. Paca st

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21680

101-001

E 21680

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 E 23 St 17-50 St. Ward)

2-FULL NAME Mamie Baylor

(a) RESIDENCE NO. 314 E 23rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Baylor

6 DATE OF BIRTH (month, day, and year): Nov. 17-1900

7 AGE: Years 27 | Months 1 | Days 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: John R. Baylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Georgania Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Ethel Shell

(Address): 314 East 23rd St.

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20 1927 to April 26 1927, that I last saw her alive on April 26, 1927, and that death occurred, on the date stated above, at 11 50 a m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No.

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) G L Hall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn-Charles Ave

Date of Burial: 4/28/1927

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21681 ANNIE

CERTIFICATE OF DEATH.

+ 74001 ✓ E 21681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4706 Harford Rd ST. 27-H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Heaton Broughton Long

(a) RESIDENCE NO. 4706 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin Daniel Long

6 DATE OF BIRTH (month, day, and year): Mar. 5. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or. ... min.
	70	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kingston Maryland

PARENTS

10 NAME OF FATHER: Elijah Broughton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Somerset Co.

12 MAIDEN NAME OF MOTHER: Harriet Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rutland Vermont.

14 Informant: Lillian Long Baines

(Address) 4706 Harford Rd

15 Filed APR 28 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 28, 1927, that I last saw her alive on April 28, 1927, and that death occurred, on the date stated above, at 9 55 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia (Right)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude Lemmix, M. D.

(Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westwood Funeral Home Md

DATE OF BURIAL: Apr 28 1927

20 UNDERTAKER: Mrs. Mrs. John H. Tumpleton

ADDRESS: 201 W. Fayette

TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

E 21682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 21682

1-PLACE OF DEATH Garden Apartments — REGISTERED NO. 13-52

CITY OF BALTIMORE: (No.) 40th & Stone Run Lane ST., (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie R. P. Cost

(a) RESIDENCE (Usual place of abode) 40th & Stone Run Lane ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred unk mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Late Rev Cyrus Cost

6 DATE OF BIRTH (month, day, and year) Dec 27th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71 72	72	3	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Joseph Poorbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER M. Meiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant Mrs Charles K Edmunds (Address) Garden Apt

15 Filed R 28 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) John J Morrison, M. D. (Coroner.)

4/27, 1927 (Address) 2632 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 28 1927

20 UNDERTAKER: Henry Jenkins & Son — ADDRESS: Eastern Ave & Collington

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21683

CERTIFICATE OF DEATH.

90 E 21683

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 741 N. Patterson Pk Ave. Ward) 9-12

2-FULL NAME Anna Mills

(a) RESIDENCE NO. 741 N. Patterson Park Ave. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: George W. Miller

6 DATE OF BIRTH (month, day, and year): Jan 15-1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Kenther

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: George W. Miller

(Address): 741 N. Patterson Park Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to April 25, 1927,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? History & Exam.

(Signed) C. F. Mills, M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: Apr 28 1927

20 UNDERTAKER: Russ C. Miller & Son

ADDRESS: 2334 E. Fayette St

APR 28 1927

Spec.—1-10-21—M&T—1500 Bks.

E 21684

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21684

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1068 W. Fairmount Ave WARD 26)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Sampson

(a) RESIDENCE NO. 1068 W Fairmount Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Leon Sampson

6 DATE OF BIRTH (month, day, and year): Oct 21. 1888

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
38	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): —

041

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Will Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Leon Sampson

(Address) 1068 W. Fairmount Ave

15 Filed APR 28 1927 19 C. HAMPTON JONES, M. D. Registrar

Per K&K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23 1927 to April 24 1927, that I last saw h er alive on April 24 1927, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) O. P. Howells M. D.

4/27 1927 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL April 28th 1927

20 UNDERTAKER: A Jones

ADDRESS 111 S. Gilmor

TION is very important See instructions on back of certificat

Cor.—1-12-23—M&T—100 Bks.

E 21685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

198 E 21685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hos. ST., 79 WARD)

2-FULL NAME Alphonsus Adams

(a) RESIDENCE NO. 49 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Major Adams

11 BIRTHPLACE OF FATHER (city or town) S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Bookhart

13 BIRTHPLACE OF MOTHER (city or town) S.C.
(State or country)

14 Informant Sarah Adams
(Address) 49 N. Dallas St.

15 Filed ..... 192 C. HAMILTON JONES, M. D.
Per R.R.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Softenting

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Stab wounds in shoulder & thigh (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pollitt, M. D.
(Coroner.)

4/27/27 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakleny Cemetry	Apr 27 192 7
20 UNDERTAKER	ADDRESS
Edwin H. Johnson	446 N. Carolina

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21686

CERTIFICATE OF DEATH

36-004

E 21686

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 804 Sterling St. W. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Jones

(a) RESIDENCE NO. 804 Sterling St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6-1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	11	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Richard Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Viola Bell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Viola Jones

(Address) 804 Sterling St.

15 Filed APR 28 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to Apr 26, 1927, that I last saw h[illegible] alive on Apr 25, 1927 and that death occurred, on the data stated above, at 5 15 P. M.

The CAUSE OF DEATH* was as follows:

Ulcer of bladder

Tuberculosis of same?

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? NK Data of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. G. Hamilton, M. D.

4/27, 1927 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Zion Cemetery — Date of Burial Apr. 30 19 27

20 UNDERTAKER Chas. H. Johnson & F. M. Coulbourne — ADDRESS

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21687

CERTIFICATE OF DEATH.

E 21687

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Rayna and Dukeland ST.) 13-59 (WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Schwartz

(a) RESIDENCE NO. 2419 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Schwartz

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Zeldo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Aaron Schwartz

(Address) 2419 Madison Ave

15 Filed APR 28 1927 [illegible] M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1927

17

I HEREBY CERTIFY, That I attended deceased from 4/24, 1927, to 4/27, 1927,

that I last saw her alive on 4/27, 1927,

and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs., mos ds.

CONTRIBUTORY (Secondary) Acute uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mach Rd — DATE OF BURIAL 4/28 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1434 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21688

CERTIFICATE OF DEATH.

89

E 21688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Rupp ST. 15-66 WARD)

2-FULL NAME Ada Sachs

(a) RESIDENCE NO. 2102 Rupp ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Sachs

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Lyock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Laura

(Address) 1439 Eutaw Place

15 Filed ..... 19 ..... Registrar

For .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May ....., 1925, to April 27, 1927, that I last saw h~ alive on April 27, 1927 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary infarct

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Levine M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herrn Rm

DATE OF BURIAL 4/29 19 27

20 UNDERTAKER Jack Laura

ADDRESS 1439 Eutaw St.

R 28 1927

Spec.—1-10-21—M&T—1500 Blks.

E 21689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 E 21689

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 11 ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Race

(a) RESIDENCE NO. 1221 Forest Rd. ST., WARD Havana Point
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. D. W Race

6 DATE OF BIRTH (month, day, and year) March 31, 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Worker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Henry Race

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Minnie Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Hagg. Road.

15 Filed R 28 1927, 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1927, to 4/27, 1927, that I last saw him alive on 4/27/, 1927, and that death occurred, on the date stated above, at 8 40 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pleurisy of Serum

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T.b.

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of 3/17/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

4/ (Signed) [illegible] M. D.

27 19 (Address) [illegible]

*State the Disease causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va. Penn. R. R.

DATE OF BURIAL April 29 1927

20 UNDERTAKER John H. Denny

ADDRESS 7 E Lights

TION is very important. See instructions on back of certificates.

Spec. 7-17-26 A Co. 200 Bks.

E 21690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 21690

REGISTERED NO.

1-PLACE OF DEATH Carmelite Convent

City of BALTIMORE: (No. Biddle + Caroline St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Raphael of Divine Province Mary Dorothy Jansen

(a) RESIDENCE NO. Carmelite Convent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): February 6 1889

7 AGE: Years 38 Months 2 Days 20 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious Nun

(b) General nature of industry, business, or establishment in which employed (or employer): 065

(c) Name of employer: Sister of Divine Province Carmelite Convent

9 BIRTHPLACE (city or town): Phila.

(State or country): Pa.

PARENTS

10 NAME OF FATHER: George Jansen

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Theresa Hettler

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Rev. Mother

(Address) Carmelite Convent Biddle + Caroline

15 Filed APR 28 1927, 19 C. HAMILTON JONES M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from March —, 1919, to April 26, 1927,

that I last saw h.e alive on April 26, 1927,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? signs + symptoms

(Signed) J. A. Blackford, M. D.

Apr. 27, 1927 (Address) 300 W Colonial Dr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Apr. 29 1927

20 UNDERTAKER: Henry Hoell & Son — ADDRESS: 1301 E. Eager St.

IMPORTANT—In plain terms, so that it may be properly classified, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

Horb

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21691

CERTIFICATE OF DEATH.

153

E 21691

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1803 Gough St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Horb

(a) RESIDENCE NO. 1803 Gough St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 Days yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 9 - 27

7 AGE: Years | Months | Days: 18 | IF LESS than 1 day.....hrs. or.....min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Edward

11 BIRTHPLACE OF FATHER (city or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: A. Dziewonkowski

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country)

14 Informant: Ed Horb

(Address) 1803 Gough St

15 Filed APR 28 1927 G. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 26 19 27, to April 27 19 27, that I last saw h[illegible] alive on April 27 19 27 and that death occurred, on the date stated above, at 7.15 A. M.

The CAUSE OF DEATH* was as follows:

Cellulitis of Neck

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Septic Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: William J. Reamer M. D.

(Address) 801 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Date of Burial 4/28/27

20 UNDERTAKER: F. O. Ozgewski ADDRESS 1930 Eastern a

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21692

CERTIFICATE OF DEATH.

11-002

E 21692

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Price

(a) RESIDENCE NO. 2043 Woodberry ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	(1)	(2) 14 mos	(6)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma M Redmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster, Pa

14 Informant Samuel Price

(Address) 2043 Woodberry ave

15 Filed ..... By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-21- 1927 to 4-27 1927.

that I last saw him alive on 4-27 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cavernous Sinus Thrombosis Left-side (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? no Date of -

Was there an autopsy? no What test confirmed diagnosis? Usual clinical examination

(Signed) C. J. Knapp, M. D.

4-27, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden — DATE OF BURIAL Apr 29 1927

20 UNDERTAKER W. A. Cook — ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21693 — 31 E 21693

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1938 E Lombard St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margreth Zoebelein

(a) RESIDENCE NO. 1938 E Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	8	7 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaking

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Paul Zoebelein

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margrit Friedrich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Dora Zoebelein

(Address) 1938 E Lombard

15 Filed APR 28 1927 H. LEAVELL JONES, M. D. Registrar

Per K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10- 1927, to Apr. 26- 1927, that I last saw h[e] alive on Apr 26 1927 and that death occurred, on the date stated above, at 12/10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis Uremia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Koenig, M. D.

Apr 27, 1927 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial April 30 1927

20 UNDERTAKER Wendell Riffelson — ADDRESS 378 Monr[oe]

Of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21694

CERTIFICATE OF DEATH

129 E 21694

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1728 Gough St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Chaney

(a) RESIDENCE NO. 1728 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Shara N Chaney

6 DATE OF BIRTH (month, day, and year) Feb 22, 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	74	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt

PARENTS

10 NAME OF FATHER Steven Chaney

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Anna Stalia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant George Chaney

(Address) 1728 Gough

15 Filed APR 28 1927 C. HAMPSON JONES, M. D. Registrar

Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/5, 1927, to 4/20, 1927

that I last saw him alive on 4/20, 1927

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

Cystitis & chronic, acute Pyuria

Uremia

(duration) yrs. mos 2a ds.

CONTRIBUTORY (Secondary) Heart failure & bronchitis

(duration) yrs. mos 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Harry A Rutledge, M. D.

, 19 (Address) 1623 Birch Cor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Harford Road) Date of Burial April 29 1927

20 UNDERTAKER Wendell Offel & Son ADDRESS 373 N

DR 28 1927

DR. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21695 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Druid Hill Ave Street) (Ward) 11-2452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Davis

(a) RESIDENCE No. 1033 Druid Hill Ave Street Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Charles Davis

6 DATE OF BIRTH (month, day, and year): — — 1856

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West River Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Benjamin Davis

(Address) 560 Penna Ave

Filed APR 28 1927 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1926 to Apr 26, 1927, that I last saw h[illegible] alive on April 26 1927, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age, has been confined to bed for two years or more, weighs about 90 lbs.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

Chronic Arthritis of five years duration

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis M. D.

4/26, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem DATE OF BURIAL 4/28/27

UNDERTAKER: Samuel Hensley ADDRESS 1700 Madison

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21696

1-PLACE OF DEATH 87 Russell St REGISTERED NO. 129

City of BALTIMORE: (No. Unknown St. 26-W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Brooks

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 5, 1919

7 AGE — Years: 7 — Months: 4 — Days: 21 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Robert Brooks

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Emeline Dixon

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Father Robert Brooks

(Address): Unknown

15 Filed....., 19..... Registrar

APR 28 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/26/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/15/ 19 27, to 4/26/ 19 27, that I last saw him alive on 4/22/ 19 27 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Hartman M. D.

4/26/ 19 27 (Address) 612 Eiland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn, Balto

Date of Burial: APR 28 1927

20 UNDERTAKER: Samuel F. Hemsley

ADDRESS 578 N Bridge

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21697

CERTIFICATE OF DEATH.

129

E 21697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 N. Chester St., 7-13 Ward)

2-FULL NAME John B. Haywood

(a) RESIDENCE NO. 908 N. Chester St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE~~ of late Emma F. Haywood

6 DATE OF BIRTH (month, day, and year) Jan 6/40

7 AGE: Years 87 | Months 3 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John Haywood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Jennie Haywood

(Address) 908 N. Chester St

15 Filed 19 Registrar

PR 28 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/14/27 19 to 4/25/27 19

that I last saw h live on 4/25/27 19

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate, cystitis, Interstitial Nephritis, Myocardial Degen

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Only

(Signed) Joseph Patowny M. D.

19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U.S. National Cem Date of Burial 4/29/27

20 UNDERTAKER: Philip Henry ADDRESS 2016 Orleans

very important. See instructions on back of certificates.

Spec.--12-9-25--A Co.--200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓

E 21698 — 1-PLACE OF DEATH

E 21698 — REGISTERED NO.

City of BALTIMORE: (No. 504 S. Streeper St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina E. Wagner

(a) RESIDENCE NO. 504 S. Streeper St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — dy.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, ~~HUSBAND~~ (or) WIFE of: late Christian Wagner

6 DATE OF BIRTH (month, day, and year): Dec 15/39

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
87	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: John Knierman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: D. H. Wagner

(Address): 3122 Tyndale Ave

15 Filed APR 28 1927 H. [illegible] (Arcadia) D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Apr 26/27

17

I HEREBY CERTIFY, That I attended deceased from April 4, 19 27, to April 26, 19 27

that I last saw her alive on April 26, 19 27

and that death occurred, on the date stated above, at 1 1 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

4/26, 1927. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews — Date of Burial: 4/29 1927

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21699 E 21699

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Harford ST. 9-18 WARD)

2-FULL NAME Naomi Dyott

(a) RESIDENCE NO. 1738 Harford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Aaron Dyott.

6 DATE OF BIRTH (month, day, and year): Feb 18/1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 Yrs	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William F. McKnight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: L. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Aaron Dyott (Address): 1738 Harford Av.

15 Filed APR 28 1927 By C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1926, to 4-27, 1927

that I last saw her alive on 4-27, 1927

and that death occurred, on the date stated above, at 1:30 P m

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Carcinoma Uterus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 10-26-25

Was there an autopsy? No

What test confirmed diagnosis? Operation Clinical Signs

(Signed) David Miller, M. D.

4/27 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wood Lawn County

DATE OF BURIAL: April 30 1927

20 UNDERTAKER: Geo. L. Ruth

ADDRESS: 1735 Harford Av

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 21700

E 21700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. ST. 66 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Leithauser

(a) RESIDENCE NO. 2045 - No. Patterson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Leithauser

6 DATE OF BIRTH (month, day, and year) Sept 19 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Toy factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leo Leithauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lewis Leithauser (Address) 45 N. Catherine St

17 Filed 12-8 1927 19 C. HAMILTON JONES, M. D. Registrar Per K M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/25, 1927, to 4/26, 1927, that I last saw h[illegible] alive on 4/26, 1927, and that death occurred, on the date stated above, at 10:05 p m.

The CAUSE OF DEATH* was as follows:

Acute ~~[illegible]~~ Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4/25/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Arvid L Jensen M. D.

4/26, 1927 (Address) West Balt Gen. Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL July 30th 1927

20 UNDERTAKER H. B. Wyckoff 155 W Baltimore St ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

149 E 21701

E 21701

REGISTERED NO.

1. PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Gonis

(a) RESIDENCE NO. 581 Warner Alley St. Walnut Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Gonis

6 DATE OF BIRTH (month, day, and year): unk.

7 AGE: Years: 26 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): "

(State or country)

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country)

14 Informant: Jesse Gonis

(Address): 581 Warner Alley

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25/27 19[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Pneumonia following child birth

(Duration) 1 mos. ds.

(Signed) J. H. Bates M. D.

(Coroner)

4/28/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Apr 28/27

20 UNDERTAKER: Dennis Easton ADDRESS: Bel. 96

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21702

CERTIFICATE OF DEATH

E 21702

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John C. Oliver

(a) RESIDENCE NO. Sewickley Penna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs John C Oliver

6 DATE OF BIRTH (month, day, and year): Oct 29 1863

7 AGE — Years: 63 Months: 6 Days: 1 29 . IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of Industry, business, or establishment in which employed (or employer): Steel Industry

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Penna

PARENTS

10 NAME OF FATHER: David B Oliver

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rebecca C. Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Penna

14 Informant: Patient on admission

(Address): to Hospital

15 Filed APR 28 1927 H. WILSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23 1927 to April 28 1927.

that I last saw h. alive on April 28 1927.

and that death occurred, on the date stated above, at 8 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver involving hepatic ducts

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Jaundice

(duration) 1 yrs. — mos. ds.

18 Where was disease contracted

If not at place of death? Sewickley, Penna.

Did an operation precede death? Yes Date of Apr. 23 '27

Was there an autopsy? No Exploratory laparotomy

What test confirmed diagnosis? —

(Signed) Lewis Olds Taynton, M. D.

19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pittsburgh Pa — Date of Burial: April 28 1927

20 UNDERTAKER: Henry W Jenkins & Son — ADDRESS: Oakland 111 Ballard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-8-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21703

CERTIFICATE OF DEATH.

112

E 21703

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 W. Fayette St. 19-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Saia

(a) RESIDENCE NO. 1603 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatrice Saia

6 DATE OF BIRTH (month, day and year) March 12½ 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Pete Saia

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Sanono

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Lucido Saia

(Address) 1603 W. Fayette St

15 Filed (19) Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion 1½ hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

April 27th. 1927 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where did disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial April 29 1927

20 UNDERTAKER W. M. Couteon ADDRESS 2228 W. Pratt

very important. See instructions on back of certificate.

R 28 1927

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21704

CERTIFICATE OF DEATH

129 E 21704

1-PLACE OF DEATH

20-67 REGISTERED NO.

City of BALTIMORE: (No. 414 Norman Avenue St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Edwardina Boswell

(a) RESIDENCE NO. 414 Norman Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Boswell

6 DATE OF BIRTH (month, day, and year): November 2, 1856

7 AGE — Years: 70 Months: 5 Days: 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Newport

(State or country): Charles County, Md.

PARENTS

10 NAME OF FATHER: Frank Ware

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Charles County, Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: J. Gibbons Boswell

(Address): 414 Norman Avenue

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1927, to Apr 26, 1927, that I last saw her alive on Apr 26, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis -

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Harry L. McCarty M. D.

4-27 19 27 (Address) 37 East Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Apr. 29 1927

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 N Calvert

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21705

CERTIFICATE OF DEATH

100-001

E 21705

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 360 St Helena Ave St. (St Helena) Ward 26-36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Hofferberth

(a) RESIDENCE NO. 360 St Helena Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 23, 1924

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	3	1	4	3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Hofferberth

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Korch

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Harry Hofferberth

(Address) 360 St Helena Ave

15 Filed ..... 19 ..... Registrar

APR 28 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 26

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 26, 1927, that I last saw h.... alive on April 26, 1927, and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. W. Kerr, M. D.

4/27, 1927 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Carmel Cemetery	Apr. 29 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1710 Fleet St.

C. HAMPSON JONES, M. D.

Registrar

Deputy

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Cause of death in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

Woytyorak

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21706

E 21706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. Port ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Woytysiak

(a) RESIDENCE NO. 622 S Port st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 26, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wladislaus Woytysiak

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Owsiak

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant Wladislaus Woytysiak
(Address) 622 S. Port Ave

15 Filed APR 28 1927 HAMILTON JONES, M. D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to April 28, 1927, that I last saw him alive on April 27, 1927 and that death occurred, on the date stated above, at 5.00 a.m.

The CAUSE OF DEATH* was as follows:

Accident of labor (145)
Breech delivery following version.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Injury at birth (161)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Marston, M. D.

4/28, 1927 (Address) 1203 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cem DATE OF BURIAL April 28 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21707

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Sharp St. ST. 72-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boylen

(a) RESIDENCE NO. 514 Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., If of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) April 25, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Earle E. Boylen

11 BIRTHPLACE OF FATHER (city or town) Grafton (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary E. Church

13 BIRTHPLACE OF MOTHER (city or town) Grafton (State or country) West Virginia

14 Informant ~~Edward Boylen~~ (Address) Mary Boylen 514 Sharp St.

15 Filed 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per 1309 RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 25, 19 27, to April 27, 19 27, that I last saw her alive on April 26, 19 27, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Prematurity - ~~Born~~ ~~month's premature weight~~ ~~4½ lbs. Did not feed well~~

(duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — da.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Alexander Norris, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19 —

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health.

APR 28 1927

Spec.—1-12-23—M&T—500 Blks.

E 21708

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21708

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 11-4-20 WARD)

2-FULL NAME Earl Glowinski

(a) RESIDENCE NO. St Vincents Inf. asylum ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Glowinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Helen Glicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) St. Vincents Inf Asylum 1401 Division St

15 Filed 4-28-1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1927

I HEREBY CERTIFY, That I attended deceased from 4-25, 1927, to 4-27, 1927.

that I last saw him alive on 4-27, 1927.

and that death occurred, on the date stated above, at 2.35 A. m.

The CAUSE OF DEATH* was as follows:

First degree burn (hot water) over entire head face & shoulder

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Toxemia from the burn.

(duration) yrs. mos. ds.

17 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual clinical findings

(Signed) A. J. Knapp. M. D.

4-27, 1927 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 4-28-27.

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1837 N [illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21709

CERTIFICATE OF DEATH.

188 803

E 21709

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital 23-34 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis A. J. Schultz

(a) RESIDENCE NO. 1702 Patapsco St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 12 1883

7 AGE — Years: 43 Months: 7 Days: 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Driver City Garbage Cart
(b) General nature of industry, business, or establishment in which employed (or employer): City
(c) Name of employer: Balto City

9 BIRTHPLACE (city or town): Balto
(State or country)

PARENTS

10 NAME OF FATHER: Robt H. Schultz

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia M. Berger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Wilhelmina Schultz
(Address) 1702 Patapsco St.

15 Filed: 1927 Per: C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Coroner) and (Physician) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
(Duration) 3 days 16 hrs.
Struck by Truck
CONTRIBUTORY (Secondary) Driver
Thos. B. Hutton M. D.
(Signed) (Coroner)

Apr 27 1927 (Address) Curtis Bay

*(State the Disease Causing Death, or In Deaths from Violent Cases, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (Give the sickness additional lines.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: April 27 To 27

20 UNDERTAKER: E. Schuman & Son ADDRESS: 1039 Hanover

very important. See instructions on back of certificate. Last statement of OCCUPA[illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21710

E 21710

CERTIFICATE OF DEATH.

25-75-89

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 827 Patapsco Ave Brooklyn St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Duckstein.

(a) RESIDENCE NO. 827 Patapsco Ave, Brooklyn St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed or divorced, HUSBAND of Carrie Duckstein.

6 DATE OF BIRTH (month, day, and year) June 24, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Carrie Duckstein. (wife)

(Address) 827 Patapsco Ave. Brooklyn.

15 Filed ____, 19____ Per C. HARTMAN COOK, M. D. Registrar

1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

Obstruction of Coronary arteries.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) Otto M Kernhardt M. D.

(Coroner)

4/23, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem Date of Burial April 30 1927

20 UNDERTAKER E Schloman & Son ADDRESS 034 Hanover

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

E 21711

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 21711

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 5109 Wayne Ave. St. 28-6 Ward)

2-FULL NAME Virginia Kate Powell

(a) RESIDENCE NO. 5109 Wayne Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Daniel Powell

6 DATE OF BIRTH (month, day, and year): Dec. 25-1850

7 AGE: Years 76 | Months 4 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Hugh Jenkins

11 BIRTHPLACE OF FATHER (city or town): Penna

(State or country)

12 MAIDEN NAME OF MOTHER: Katherine Kuark

13 BIRTHPLACE OF MOTHER (city or town): Penna

(State or country)

14 Informant: Mrs. J. Milner Poteet

(Address) 5109 Wayne Ave.

8 1927 C. HAMPSON JONES M. D.

19 _____

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 26 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to April 26, 1927, that I last saw h[illegible] alive on April 26, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis &
Mitral Insufficiency.

(duration) 1 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary): Arthritis Deformans

(duration) 4 yrs. ___ mos. ___ ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Henry Botchey, M. D.

4/27. 1927. (Address) 65 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. Date of Burial Apr. 29 1927

20 UNDERTAKER: Wm. E. Black ADDRESS 927 N. Broadway

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21712

CERTIFICATE OF DEATH.

188-002

E 21712

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St., 9-46 Ward)

2-FULL NAME William R. Lister

(a) RESIDENCE NO. 900 Homestead St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. -- mos. ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearle Middleton

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shop Man

(b) General nature of industry, business, or establishment in which employed (or employer) United Railway

(c) Name of employer & Electric Co.

9 BIRTHPLACE (city or town) Talbott Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Willard Lister

11 BIRTHPLACE OF FATHER (city or town) Talbott

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Cross

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant (Address) Mrs. Pearle V. Lister 900 Homestead Street

Filed 4-28-27 C. HAMILTON JONES, M. D. Registrar

Burial Via Tolchester Steamboat Co. Escort - Mrs. Pearle H. Lister

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. base of skull caused by accidently falling from top of Car Electric at Bath & Eden Sts.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

Apr. 28 (Signed) [illegible] M. D. (Coroner)

, 19 27 (Address) 1037 Bradley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piney Neck, Kent Co., Md. Date of Burial 4/30 19 27

20 UNDERTAKER Henry W Meade & Son ADDRESS 805 N Calvert St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 21713

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21713

CERTIFICATE OF DEATH.

1290

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Belair Road & Kenwood ST., (Ward)

2-FULL NAME Wilton Bond

(a) RESIDENCE NO. Belair Road & Kenwood Ave. Overlea ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md Md.

PARENTS

10 NAME OF FATHER: William Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Mrs Barbara Eggriat

(Address): Overlea Md.

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per A.C.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927, to April 26, 1927, that I last saw h alive on April 26, 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arterial Hypotension
Myocardial Degeneration.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: April 29, 1927

20 UNDERTAKER: Frederick Boehm — ADDRESS: Fullerton

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21714

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21714

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N. Bradley St., 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David C. King

(a) RESIDENCE NO. 620 Bradley ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	19	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph C King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nora Mahony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elnora King sister (Address) 620 Bradley St.

15 4-28-1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to April 24, 1927, that I last saw h[illegible]ive on April 25, 1927, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T-B-C.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) uncertain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. H. Jones, M. D.

, 19 (Address) 1424 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 29/1927

20 UNDERTAKER David Taylor

ADDRESS 916 Gay

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Rosenblatt Bonfil Hosp

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21715

CERTIFICATE OF DEATH.

E 21715

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Hudson ST., 1-1 WARD)

2-FULL NAME Louisa Phillips

(a) RESIDENCE NO. 2911 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Phillips

6 DATE OF BIRTH (month, day, and year) May 23, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Falls Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Falls Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary E Phillips

(Address) 2911 Hudson St

Filed APR 29 1927 H. Hayes Jones M

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to April 28, 1927, that I last saw her alive on April 28, 1927, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 2 hours

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) Unknown

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Jos. T. Rosenblatt, M. D.

4-28, 1927 (Address) 3018 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL April 28 1927

20 UNDERTAKER J. M. Cook — ADDRESS 502 E Monument

Spec.—1-12-23—M&T— 00 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21716

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 21716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2917 Parkwood Ave St. 13-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalia M Boyly

(a) RESIDENCE NO. 2917 Parkwood Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas R. Boyly

6 DATE OF BIRTH (month, day, and year): Jan 26 1847

7 AGE — Years: 80 — Months: 3 — Days: 22 — If LESS than 1 day, hrs or min:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. R Boyly

(Address) 2917 Parkwood Ave

Filed APR 29 1927 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/25, 1927, to 4-27, 1927.

that I last saw her alive on 4-27, 1927

and that death occurred, on the date stated above, at 9.25 P m

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Dr [illegible], M. D.

4/28, 1927 (Address) 1928 N Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Apr 30 1927

20 UNDERTAKER: D. J. Cook

ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 21717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Brooklyn 75-75 129

1-PLACE OF DEATH

REGISTERED NO. 21717

CITY OF BALTIMORE: (No. 414 Potomac Ave ST. 75-75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Hamlen

(a) RESIDENCE NO. 414 Potomac Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 19 1909

7 AGE — Years: 17 — Months: 11 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James H Hamlen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna M Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James H Hamlen (Address) 414 Potomac Ave

15 [illegible] C. HAMILTON JONES, M. D. Registrar

Per [illegible]

APR 29 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 27, 1927, that I last saw him alive on April 26, 1927 and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. H. Lupton, M. D.

4/29, 1927 (Address) 301 Elmora Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 30 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21718

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 21718

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 316 N. Poppleton St. 18-7b Ward)

2-FULL NAME Ernest C. Wells

(a) RESIDENCE NO. 316 N poppleton St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug-28-1890

7 AGE 36 · Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
37	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Printing

(c) Name of employer self.

9 BIRTHPLACE (city or town) Baltimore

(State or country) md.

PARENTS

10 NAME OF FATHER Charles H. Wells

11 BIRTHPLACE OF FATHER (city or town) Howard Co.

(State or country) md.

12 MAIDEN NAME OF MOTHER Henrietta Dennis

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) md.

14 Informant Charles E. Wells

(Address) 626 Lexington St.

Filed APR 29 1927 C. HAVILAND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-1927

17 I HEREBY CERTIFY, That I attended deceased from 3/2/ 1927, to 4-25, 1927, that I last saw him alive on 4-25, 1927, and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

Acute Dilatation of Heart

Terminal Bronchopneumonia (duration) yrs. mos. 5 ds.

CONTRIBITORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/27 1927 (Address) 808 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — Date of Burial April 29 1927

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21719 + 90 E 21719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital No 1. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore Md ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clemente Da Silva.

(a) RESIDENCE NO. 17 Hamilton Ct ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Brooklyn N.Y. yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 25 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer S/S Curacao

9 BIRTHPLACE (city or town) (State or country) Portugal

PARENTS

10 NAME OF FATHER Clemente da Silva

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portugal

12 MAIDEN NAME OF MOTHER Rose Jedaas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portugal

14 Informant self.

(Address)

15 Filed ..., 19 ... Registrar

APR 29 1927 HARRY JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 25, 1927, to Apr 27, 1927, that I last saw him alive on Apr 27, 1927, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

aortic and mitral lesions

(duration) yrs. 1 (?) mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical findings & laboratory tests

(Signed) W.W. Benton, M. D.

4-28, 1927 (Address) A.A. Surgeon U.S.P.H.S. U.S. Marine Hospital, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Hampden DATE OF BURIAL Apr 30 1927

20 UNDERTAKER E. LeRoy Stuffler ADDRESS 1252 North Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21720

CERTIFICATE OF DEATH.

E 21720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2401 E. Oliver ST. 8-16 WARD)

2-FULL NAME Veronica Leitzes

(a) RESIDENCE NO. 2401 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Leitzes

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia Europe

PARENTS

10 NAME OF FATHER Frank Stockel

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country) Europe

12 MAIDEN NAME OF MOTHER Ford Knox

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Joseph Leitzes Son of Deceased

(Address)

15 Filed 29 1927 19 C. HAMILTON JONES, M. D. Per RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1927, to Apr 27, 1927, that I last saw h[illegible] alive on Apr 27, 1927, and that death occurred, on the date stated above, at 1 00 m.

The CAUSE OF DEATH* was as follows:

Cardiac Respiratory Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) T. Roderick E. Reeves, M. D

Apr 27 1927 (Address) 1301 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill Cemetery — DATE OF BURIAL Apr. 30 1927

20 UNDERTAKER Zinkler & Zinkler — ADDRESS 1739 E. Eager

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21721

CERTIFICATE OF DEATH.

9188-002 E 21721

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy U. Hos. St., Lombard & Green 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Taylor

(a) RESIDENCE NO. 2127 Callow Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Cole Taylor

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 68 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 010

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): "

(State or country)

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country)

14 Informant: Dora Trice Taylor

(Address) 2127 Callow Ave

15 Filed....., 19..... Registrar

APR 29 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Railway accident

No

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Reamer L. Trusk M. D.

(Coroner)

19 2, (Address) 332 S Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Maryland Date of Burial Apr 1 1927

20 UNDERTAKER: John Ottitschell ADDRESS 1900 Eutaw Place

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21722

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 21722

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud L Cornish

(a) RESIDENCE NO. 2445 McCullough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robt. Cornish

6 DATE OF BIRTH (month, day, and year) May 1897

7 AGE 29	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isaih Lampson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Octavia Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Isaih Lampson

(Address) 2445 McCullough St

Filed APR 29 1927 C. HAYS JONES, M. D. Registrar

By R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Cain M. D.

(Coroner)

4/29/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial Apr. 29 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Eastlake Ave

Fill in all blanks if possible. Use ditto marks if necessary. Each statement is required by law to be given as accurately as possible. Physician or midwife in charge of case is required to sign certificate. Read carefully instructions on back of certificate. Every question is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

E 21723

CERTIFICATE OF DEATH.

E 21723

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 S. Robinson St. St. 1-V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Pilachowski.

(a) RESIDENCE NO. 7 S. Robinson St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9y yrs. ____ mos. ____ dy. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ dy.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21-1927

7 AGE: Years ____ Months ____ Days 7 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Pilachowski

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Stadter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant John J. Pilachowski

(Address) 17 S. Robinson St.

15 Filed _____ 19____ C. HAMILTON JONES, M. D. Registrar

R 29 1927

R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28-1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 28, 1927, that I last saw him alive on " 28, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation

(duration) ____ yrs. ____ mos. 8 ds.

CONTRIBUTORY (Secondary) Malformation

(duration) ____ yrs. ____ mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. C. Rice, M. D.

4/28/27 (Address) 408 S. Bat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial April 30 1927

20 UNDERTAKER: Tilly & Fuller ADDRESS 403 S. Wolfe St.

very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

E 21724

CERTIFICATE OF DEATH

75 E 21724

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2209 E Lombard St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Heyman

(a) RESIDENCE NO. 2209 E Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S. If of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General natore of indostry, bosiness, or establishment in whieh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Abraham Lamet

11 BIRTHPLACE OF FATHER (City or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Fagie Nik.

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14 Informant David Heyman

(Address) 910 S Charles st

15 Filed APR 29 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 3 1927 to April 28 1927 that I last saw h[illegible] alive on April 28 1927 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Embolic)

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted at home

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Lychus, M. D.

19 (Address) 320 N. Garrison Blvd

April 28 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd. Date of Burial 4/29 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 112 E Baltimore st

very important. See instructions on back of certificates.

Statement of OCCUPATION is

Spec. -7-17-26 -A Co.—200 Bks.

E 21725

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 21725

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Bon Secours Hos St. 1124 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Hite

(a) RESIDENCE NO. Albion Hotel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Drayton M. Hite

6 DATE OF BIRTH (month, day, and year): May 16. 1850

7 AGE: Years 76 Months 11 Days 12, IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: James Curran

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Hester Ann Sund

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Alice Hilberg

(Address) 754 Reservoir St

15 Filed [illegible], 1927 C. H. JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1925, to April 28, 1927 that I last saw h.er alive on April 27, 1927 and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John B. Young M. D.

, 19 (Address) 704 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Apr 30 1927

Date of Burial

UNDERTAKER: John O. Mitchell

ADDRESS: 1900 Eutaw Place

If DEATH OCCURRED IN PLACE OTHER THAN RESIDENCE, give information called for in items 16 and 17 on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128

E 21726

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 N. Calhoun St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Gaskins

(a) RESIDENCE NO. 511 Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE 61 Years 59 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Baltimore Co.

PARENTS

10 NAME OF FATHER Dennis Gaskins

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Clarence O'Neil

(Address) 511 N. Calhoun St.

15 Filed 4-29 1927 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 19 27, to Apr 26, 19 27

that I last saw h[illegible] alive on Apr 26, 19 27

and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH was as follows:

Acute Pulmonary Tuberculosis Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. N. Hatcher, M. D.

4/29, 1927 (Address) 1225 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 4/29 1927

20 UNDERTAKER Samuel Beasley ADDRESS 578 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ E 21727

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals St. (4-25) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Moore

(a) RESIDENCE NO. 625 W. Mulberry st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: John Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Pantha Walter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Georgia

14 Informant: Hospital Records

(Address)

15 Filed ....., 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927 to April 24, 1927, that I last saw h.. im alive on April 24, 1927, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gaither, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial April 29 27

20 UNDERTAKER: Samuel Straley & Bro. ADDRESS

very important. See instructions on back of certificates.

C. HAMILTON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21728

E 21728

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 222 N Amity ST. (WARD) 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child of Clarence & Lucy Hall

(a) RESIDENCE NO. 222 N Amity ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 23, 1927

7 AGE: Years — Months — Days 4 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Clarence Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lucy Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Knoxville Tenn

14 Informant: Joseph Harris

(Address): 1102 Wagon Alley

15 Filed APR 29 1927 C. HAMPTON JONES, M. D. Registrar.

Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23 1927 to April 27 1927 that I last saw him alive on April 27 1927 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Howell M. D.

4/28/1927 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: April 29 1927

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21729

CERTIFICATE OF DEATH.

113 ✓

REGISTERED NO. E 21729

1-PLACE OF DEATH

City of BALTIMORE: (No. WILSON SANITARIUM St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Lee White

(a) RESIDENCE NO. 2310 Cambridge St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-28-26

7 AGE — Years: — Months: 7 — Days: 0 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER Sam White

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Lillie Shar

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Relative

(Address) JOHNS HOPKINS HOSPITAL, E. MONUMENT & WOLFE STS., N. E.

15 Filed, 19 APR 29 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1927, to April 25, 1927, that I last saw h.. alive on April 25, 1927, and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute primary

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute gastro-intestinal indigestion (duration) 7 wks yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J A Price, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Apr 29 1927.

20 UNDERTAKER: M J Sadowski — ADDRESS: 705 S Ann

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21730

CERTIFICATE OF DEATH

100-001 E 21730

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 204 S. Durham St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Kapinus,

(a) RESIDENCE NO. 204 S. Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17/27.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N/D

(b) General nature of industry, business, or establishment in which employed (or employer) None,

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.,

(State or country) MD.

PARENTS

10 NAME OF FATHER Frank Kapinus,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Anna Pisz,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Frank Kapinus, (Father)

(Address) 204 S. Durham Street

15 Filed APR 29 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to April 28, 1927, that I last saw him alive on April 28, 1927, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows: It was an 8 months baby, lack vitality, had to use forced feeding, Malnutrition

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph Pokarny M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Stanislaus. Date of Burial Apr. 30 1927

20 UNDERTAKER M. J. Sadowski ADDRESS 935 S. Ann

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

212 397 E 21731

101-006 E 21731

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOS... St. 6-10 Ward)

2-FULL NAME Samuel Greenberg

(a) RESIDENCE NO. 2119 E. Fairmont St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 - 917

7 AGE: Years 10 | Months 3 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper and School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md - Baltimore city Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel Greenberg

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER Lena Kolker

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Records - (Address) JOHNS HOPKINS HOS

15 Filed 4 29 1927 C. HAMPSON JONES, M. D., Registrar.

By RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23 1927, to April 24 1927, that I last saw h.. alive on April 24 1927, and that death occurred, on the date stated above, at 10 AM m.

The CAUSE OF DEATH* was as follows: Pneumonia - Bilateral

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia (?)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 4/29 1927

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Baltimore St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21732

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) V 13 Walnut St. 17th (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Campbell

(a) RESIDENCE NO. V 13 Walnut St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lompta

6 DATE OF BIRTH (month, day, and year): 1879-

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Market

(c) Name of employer: Wyserong

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Peter Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bath Md

12 MAIDEN NAME OF MOTHER: Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bath Md

14 Informant: Henry Reed (Address) 930 E. Baltimore St.

15 Filed 29 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/28/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/24/27 to 4/28/27, 19

that I last saw him alive on 4/27/27, 19

and that death occurred, on the date stated above, at 5:30 A, m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos 4 ds. Syphilis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

4/29/27 (Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: April 30/1927

20 UNDERTAKER: Daniel Easton

ADDRESS: Pine

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21733

CERTIFICATE OF DEATH.

44 E 21733

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1913 N Fulton ST. 15-21 WARD)

2-FULL NAME Philip Henry Voll

(a) RESIDENCE No. 1913 N. Fulton ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma M. Voll

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	23 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Leather Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis Voll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Emma M Voll

(Address) 1913 N Fulton Ave

15 Filed ..... 19 ..... Registrar

29 1927 C. HAMPSON JONES M.D. Dep. REB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1925, to April 27, 1927, that I last saw him alive on April 27, 1927 and that death occurred, on the date stated above, at 7.45 pm

The CAUSE OF DEATH* was as follows:

Cardiac & respiratory failure Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of liver & Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physicians

(Signed) Thos Jones M. D.

(Address) 1744 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Apr 30 1927
20 UNDERTAKER	ADDRESS
The J. Treacy Sons	N. Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21734

CERTIFICATE OF DEATH.

46 E 21734

1-PLACE OF DEATH 507 Mosher St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 507 ST. 14-20 WARD)

2-FULL NAME Mary Anna Martin

(a) RESIDENCE NO. 507 Mosher St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank P Martin.

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 40 | Months ? | Days ? | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Matthew Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Julia O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Frank P. Martin.

(Address) 507 Mosher St

15 Filed APR 29 1927 Per H. W. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 1927, to Apr 27. 1927.

that I last saw h[illegible] alive on Apr 25. 1927.

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Digital exam

(Signed) H. W. Jones, M. D.

Apr 29, 1927 (Address) 2105 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 4-30-27

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1827 W North Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 21735 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21735

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 Washington Blvd (Ward) 17-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kazys Adomaitis

(a) RESIDENCE NO. 637 Washington Blvd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. / mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years 58 Months ~ Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Baister

(c) Name of employer Pijus Adomaitis

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Stanley Adamaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Gedruta Jusaitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs. Pius Adams (Address) 637 Washington Blvd

15 Filed 2 9 1927 C. HAMPSON JONES M. D. (Registrar)

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 25, 1927, that I last saw him alive on April 25, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Barbuses M. D.

4/28, 1927 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL 4/30 1927

20 UNDERTAKER Chas. P. Luckman ADDRESS 637 Wash't

TION IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21736

CERTIFICATE OF DEATH.

E 21736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 St. Paul St. ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Diller Lynch

(a) RESIDENCE. NO. 3832 Park Heights Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Lynch

6 DATE OF BIRTH (month, day, and year): July 26 1839

7 AGE: Years 88 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Diller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Hannie E. Mathias

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Henry Arnold

(Address) 3832 Park Heights Ave.

15 Filed APR 29 1927 19 C. HAMPSON JONES, Registrar. M. D.

Per Rob

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl. 29 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927 to Apl. 29 1927 that I last saw h.. alive on Apl. 27 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Apl 29-1927

Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Johnson M. D.

(Address) 1206 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St John. Westminster — DATE OF BURIAL: 5/2 1927

20 UNDERTAKER: H Bankard & Son — ADDRESS: Westminster Md

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21737

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21737

CERTIFICATE OF DEATH.

+90

1-PLACE OF DEATH

Registered No. 15-61

City of BALTIMORE: (No. 3411 Piedmont av St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Upton S. Landers

(a) Residence No. 3411 Piedmont av St., Ward. Middleburg Md,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 25 56

7-AGE. 70 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robert Landers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England.

12-MAIDEN NAME OF MOTHER, Martha Otto

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Jos Douglas

(Address) 3411 Piedmont

15- Filed 3 1927 C. HAMPSON JONES, M. D. Registrar. Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apl 28 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 17th, 1927 to Apl 28th, 1927

that I last saw h.[illegible] alive on Apl 27th 1927

and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

Dilatation of the Heart

(Duration) yrs. 2 mos. ds

CONTRIBUTORY (Secondary) Mitral Incompetency

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas M. D

, 19 (Address) 3043 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Middleburg Md. DATE OF BURIAL: April 30. 1927

20-UNDERTAKER: H M Routson ADDRESS 223 St Westminster

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-12-23—M&T—500 Bks.

S. Sain 1509 N. Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21738

CERTIFICATE OF DEATH.

101-401

E 21738

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 N. Caroline ST., 9-17 WARD)

2-FULL NAME Raymond Shoemaker Gorsuch

(a) RESIDENCE NO. 1707 N. Caroline ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 17 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	20		22 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George R. Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Shoemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant George R. Gorsuch (Address) 1704 N Caroline

15 Filed Apr 29 1927, 19 C. THAYSON JONES, M. D. Registrar Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1927, to Apr 29, 1927, that I last saw him alive on Apr 29, 1927, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) ....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) C. G. Davis, M. D.

, 19 (Address) 1509 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL May 2 1927

20 UNDERTAKER H. M. Cook — ADDRESS 502 E Monument

Spec.—1-12-23—M&T—500 Bks.

Dr Hill 3711 Liberty Heights Ave.

E 21739 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21739

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1638 N. Calvert St. 17-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eloise Freeman

(a) RESIDENCE NO. 1638 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chester M Freeman

6 DATE OF BIRTH (month, day, and year): July 17. 1874

7 AGE: Years 52 | Months 9 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chester M Freeman

(Address): 1638 N Calvert St

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1927

17

I HEREBY CERTIFY, That I attended deceased from April 25 , 1927 , to 4. 25 , 1927 ,

that I last saw her alive on 4. 25 27 , 19 ,

and that death occurred, on the date stated above, at about 11 P m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs about 1 mos 7 days ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W F Hill, M. D.

, 19 (Address) 3711 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 2 1927

20 UNDERTAKER: Tony Cook

ADDRESS: 502 E Nalls Alley

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21740

70 E 21740

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1735 Bank St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Majcher Bagrocki

(a) RESIDENCE NO. 1735 Bank St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bagrocki

6 DATE OF BIRTH (month, day, and year) Jan 3 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	65	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

t0 NAME OF FATHER Unknown

t1 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

t2 MAIDEN NAME OF MOTHER Unknown

t3 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Sophia Klikczynski

(Address) 1735 Bank St

15 APR 29 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year) April 28 1927 t9

t7 I HEREBY CERTIFY, That I attended deceased from April 23 1927 to April 27 1927.

that I last saw him alive on April 27 1927.

and that death occurred, on the date stated above, at 1 30 P. M.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

t8 Where was disease contracted ?

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry J. Riley, M. D.

4/29, 1927 (Address) 2502 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

t9 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial May 2 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

196

E 21741

1-PLACE OF DEATH U. S. Industrial Chemical Co.

City of BALTIMORE: (No. Fairfield. St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Deshields.(C)

(a) RESIDENCE NO. 1054 Argyle Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. dt. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or WIFE of): Susie Deshields.(C)

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Deshields.(C)

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Mills.(C)

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland.

14 Informant: Goldie Billiams.(C) cousin.

(Address): 1054 Argyle Ave.

15 Filed 30 1927 C. HAMILTON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental electrocution

Came in contact with electric cement mixer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto H. Leimandt M. D.

(Coroner)

4/28 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Snow Hill. Md Date of Burial 4-30, 27

20 UNDERTAKER: John H. Toadvine ADDRESS Quad Hill

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21742

CERTIFICATE OF DEATH.

E 21742

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 W. Hoffman St. 11-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Quigley

(a) RESIDENCE NO. 209 W. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin Quigley

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country): Balto.

PARENTS

10 NAME OF FATHER: Wesley Walker

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Harriett Walker

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Benjamin Quigley

(Address): 209 W. Hoffman St.

15 Filed 1927 H. HANSON JONES, M. D. Registrar

Per ARB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) No history

(duration) yrs. mos. ds.

(Signed) J. J. Young M. D.

(Coroner)

(Address) 2402 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial 4/30 1927

20 UNDERTAKER: Samuel Brinsley ADDRESS: W. Balto

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21743

CERTIFICATE OF DEATH.

17° E 21743

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. St. 17-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ollie Burton

(a) RESIDENCE NO. 751 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ethel Burton

6 DATE OF BIRTH (month, day, and year): April 12-1889

7 AGE — Years: 38 Months: Days: 15 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ice cream Mfr

(b) General nature of industry, business, or establishment in which employed (or employer): Maker.

(c) Name of employer

9 BIRTHPLACE (city or town): Richmond

(State or country): Va

PARENTS

10 NAME OF FATHER: Jack Burton

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Jane —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Marie Burton

(Address) 1302 Harlem Ave

15 Filed ..... 19 ..... Registrar HAMILTON JONES M D

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 7,

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of head. (Revolver)

Self inflicted

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Kelly M. D.

(Coroner)

(Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va Date of Burial: 4-30 1927

20 UNDERTAKER: Samuel Hinds ADDRESS: W Fdle

very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21744

CERTIFICATE OF DEATH.

90 E 21744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 N Calvert ST. 12 WARD)

2-FULL NAME Raymond A. White

(a) RESIDENCE NO. 2606 N. Calvert ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvina A. F. White

6 DATE OF BIRTH (month, day, and year) Aug 25th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Vice President
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hess Typewriter Supply Co

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Alvina A. F. White
(Address) 2606 N. Calvert st

R 30 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 192 7

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Witness) , M. D.

4/29 , 192 7 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 4/30/ 192 7

20 UNDERTAKER Geo. Weber & Son ADDRESS 2508 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

E 21745

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21745

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McNeal

(a) RESIDENCE NO. 213 E. Cross St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. L. McNeal.

6 DATE OF BIRTH (month, day, and year) (Unknown) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Cain

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Harvy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

MAY 10 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 29, 1927, that I last saw h[illegible] alive on April 29, 1927, and that death occurred, on the date stated above, at 9:55 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Gen'l Laboratory

(Signed) [redacted] M. D.

, 19 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co Date of Burial 5-3 1927

20 UNDERTAKER E & B Hahn ADDRESS 115 E 21st St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21746

CERTIFICATE OF DEATH

E 21746

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE, (No. 20-20 ST. WARD)

REGISTERED NO. 100201

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Samuel Jones

(a) RESIDENCE NO. 507 Edgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Cara Jones

6 DATE OF BIRTH (month, day, and year) May 15 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records

(Address)

Filed APR 30 1927, 19 C. HAYDEN JONES M. D. Registrar

Per Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/23, 1927, to 4/27, 1927, that I last saw h/m alive on 4/27, 1927, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Jones Jr M. D.

, 19 (Address) Thos A Jones Jr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL 4/30 1927

20 UNDERTAKER Harry A Witzke

ADDRESS 1531 W Lombard St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21747 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21747

CERTIFICATE OF DEATH.

90

REGISTERED NO. 14-29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1324 W. Pratt St. (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Feeley

(a) RESIDENCE NO. 1324 W. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Feeley

6 DATE OF BIRTH (month, day, and year) March 14, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Leo Feeley (Address) 1324 W Pratt St

15 Filed 4 30 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 19 27

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to April 29, 19 27,

that I last saw h alive on April 29, 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 2 Yrs.

Chronic Myorcorditis 2 Yrs.

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ben. V. Carolenus M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cathedral — DATE OF BURIAL May 2 1927

20 UNDERTAKER John H Fields — ADDRESS 1200 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

E 21748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 356 S Smallwood St., W-69 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Conrad Wick

(a) RESIDENCE NO. 356 S Smallwood St., WARD ..
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27 - 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George C. Wick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katharyn Eick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Geo. C. Wick

(Address) 356 S. Smallwood St.

FILED ... 1927 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to April 28, 1927, that I last saw him alive on April 28, 1927, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Acute Hypostatic Pneumonia.
Myocarditis. (Contributory)

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos 2 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norman O. Ketach M. D.

4/29, 1927 (Address) 2151 N Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Apr. 30 1927

20 UNDERTAKER George L. Schwab — ADDRESS 2101 Eutaw Ave.

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21749

CERTIFICATE OF DEATH

90 E 21749

1-PLACE OF DEATH

REGISTERED NO. 25-75

City of BALTIMORE: (No. 100 N. Sixth St., Brooklyn St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Francis

(a) RESIDENCE NO. 100 N. Sixth St., Brooklyn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Sarah E. Francis

6 DATE OF BIRTH (month, day, and year) May 27, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
70	71	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Yard Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. 03

(c) Name of employer

9 BIRTHPLACE (city or town) Providence,

(State or country) Md.

PARENTS

10 NAME OF FATHER James Francis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah A. Blakeley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Sarah E. Francis

(Address) 100 N. Sixth St, Brooklyn

15 Filed C. HARRISON JONES, M. D. Registrar

0 1927 Per

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5th, 1927, to April 27th, 1927, that I last saw him alive on April 26th, 1927, and that death occurred, on the date stated above, at 10.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation

(duration) — yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? At place of death

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Oran J. Heckel, M. D.

4/29 1927 (Address) 1224 E Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial April 30 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Bks.

E 21750

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Laynn and Dukeland ST., 3-5 WARD)

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Goldstein

(a) RESIDENCE NO. 1113 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	nr	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Goldstein

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Feedman

(Address) 113 E Pratt St

30 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/27/ 1927 to 4/29 1927, that I last saw h~~er~~ alive on 4/29 1927, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	4/30 1927
20 UNDERTAKER	ADDRESS
Jack Laurs	1439 E Balt St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21751 | CERTIFICATE OF DEATH. | E 21751

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-64 Ward) 188-003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman E. Shopsin

(a) RESIDENCE NO. 3804 Forrest Park St. are Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hortense Shopsin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 35 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): New York C

(State or country): ~~Russia~~

PARENTS

10 NAME OF FATHER: Moses Shopsin

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Nathan Silverman

(Address): 3804 Forrest Park Ave

15 Filed ..... 19 .....

Per ..... Registrar

C. HARTMAN JONES, M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra Cranial & thoracic Hemorrhage

Automobile Collision - Alredale & Sequoia Aves

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Collins M. D.

(Coroner)

4/30/19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem Date of Burial: 5/1 1927

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Baltimore St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 21752

HEALTH DEPARTMENT—CITY OF BALTIMORE

146 E 21752

CERTIFICATE OF DEATH

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO. 13-59

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Canning

(a) RESIDENCE NO. 825 Burke's Lane St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Canning

6 DATE OF BIRTH (month, day, and year): 1903 (?)

7 AGE: Years 24 Months ? Days ? IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Berman Cooper

11 BIRTHPLACE OF FATHER (City or town) ____
(State or country): Russia

12 MAIDEN NAME OF MOTHER: Anna Cooper

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country): Russia

14 Informant: Jerome J. Gebhart
(Address): 2504 Reisterstown Road

30 1927, 19 (HAYDEN JONES) Registrar
Per ACW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: April 28,

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to April 28, 1927, that I last saw her alive on April 25, 1927, and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcus viridans Septicaemia

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary): Acute nephritis, pneumonia and pregnancy (2 mo)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted? ?

if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Bacterial - blood culture

(Signed) Lemuel W. Cox, M. D.

. 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nehrem Lovedale — Date of Burial: 5/1 1927

20 UNDERTAKER: Jack Lewis 1439 — ADDRESS: E Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21753

CERTIFICATE OF DEATH.

E 21753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 96-37 Ward

2-FULL NAME Willie Graham

(a) RESIDENCE NO. Non-resident St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2days yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890 ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Dan Graham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Hanna Small

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed C. HAMILTON JONES M. D. Registrar

1927 Per 1332

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927 to April 27, 1927

that I last saw him alive on April 27, 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Syphilis (tertiary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage 15 min.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) W. E. Gallaway M. D.

4-28-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND APR 30 1927

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21754

CERTIFICATE OF DEATH.

E 21754
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Myers

(a) RESIDENCE NO. 1705 Carlyle Place St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-9-18

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	8	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): Girl

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Myers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Reported

(Address) JOHNS HOPKINS HOSP.

15 Filed ..... 19 ..... Registrar

30 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1927, to April 28, 1927, that I last saw her alive on April 28, 1927, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary and general tuberculosis.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J A Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cubley Date of Burial Apr 30 27

20 UNDERTAKER: Mrs. A. G. Elliott ADDRESS 220 Cathedral

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 714 N. Eden St. 10-14 Ward)

REGISTERED NO. 1001 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arch Gibson

(a) RESIDENCE NO. 714 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gibson

6 DATE OF BIRTH (month, day, and year) Unknown 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia or Unknown.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Gibson (Address) 714 N. Eden St.

15 Filed 4/30 1927 C. HAMPTON JONES, M. D. Registrar

Per RPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to April 29, 1927, that I last saw him alive on April 26, 1927, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

4/29 1927 (Address) 733 Arsenal St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Cemetery — DATE OF BURIAL April 30 1927

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1722 Baseland

Spec.—1-12-23—M&T—500 Bks.

E 21756

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital.

CITY OF BALTIMORE: (No.) Caroline & Oliver ST., 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Anthony -

(a) RESIDENCE NO. Sparrows Point Md ST., 808 J. St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro.	Married.

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Herbert Anthony -

6 DATE OF BIRTH (month, day, and year) Nov. 2. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER William Tyns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Wallow.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Herbert Anthony

(Address) Sparrows point

15 Filed 30 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 29, 1927.

that I last saw her alive on April 29, 1927

and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Toxic adenoma of thyroid.

Myocarditis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Clement C. Norris, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Smith Field Va

DATE OF BURIAL May 2 1927

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1745 Eastland Ave

Spec.—1-10-21—M&T—1500 Bks.

E 21757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21757

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Evergreen av ST. 27-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Bankard

(a) RESIDENCE NO. 114 Evergreen av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6-1851

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Bankard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ann Harryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore-md

14 Informant: Walter F Bankard

(Address) 201 Aisquith Ave

15 Filed 0 1927

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to April 29, 1927, that I last saw him alive on April 28, 1927 and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver & Stomach

(duration) 1 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility & Arterio-Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. Carman, M. D.

4-29-1927 (Address) 1701 N. Carrollton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 2 1927

20 UNDERTAKER: George J Smith — ADDRESS: Hollins

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21758

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1031 N. Caroline St. St. 9-13 Ward) 90

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie E. Meyer

(a) Residence No. 1031 N. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hans H. A. Meyer

6-DATE OF BIRTH (month, day and year) 10. 12. 60.

7-AGE, 66 yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER James Lipp

11-BIRTHPLACE OF FATHER (city or town) Balto. Md (State or Country)

12-MAIDEN NAME OF MOTHER Charlotte A. Davis

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country) Md

14- (Informant) Hans H. A. Meyer

(Address) 1031 N. Caroline

15- Filed ... 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 28, 27.

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1926, to Apr. 28, 1927, that I last saw h. alive on Apr. 26, 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Ren.

Endo & Myo cardetis

Mitral Regurgitation

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam'n

4/29, 1927 (Signed) W. R. Peters, M. D. (Address) 1 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL, May 2, 1927

20-UNDERTAKER, Frank A. Fink ADDRESS 915 N. Gay St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21759

E 21759

CERTIFICATE OF DEATH.

188-002

E 21759

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) N. Baltimore Lewis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Mitchell

(a) RESIDENCE NO. 3410 Mondawmin Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. H. Mitchell

6 DATE OF BIRTH (month, day, and year): Mar. 28th 1842

7 AGE: Years 85 Months 1 Days 0 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Dorchester Co

(State or country): Md

PARENTS

10 NAME OF FATHER: John Mfr.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Addie Green

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mrs. Kramer

(Address): 3410 Mondawmin Ave

15 Filed ..... 19..... C. HAMPTON JONES, M. D. Registrar

R 30 1927

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental)

..... (duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Struck on accident.

..... (duration) .....yrs. .....mos. .....ds.

(Signed) J. C. T. Hennessy (Coroner) M. D.

April 29 1927 (Address) 2807 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: 4/30 1927

20 UNDERTAKER: M. J. Tucker & Sons ADDRESS: Penna & North

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21760 21760

CERTIFICATE OF DEATH.

74-001 E 21760

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2037. Woodberry Avenue. ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Harris.

(a) RESIDENCE NO. 2037. Woodberry Avenue. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	white	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) ~~--------~~ Elizabeth J. Harris.

6 DATE OF BIRTH (month, day, and year) October 13/1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	63.	6.	17	

8 OCCUPATION OF DECEASED Brick Layer.

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

011

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland.

PARENTS

10 NAME OF FATHER Jehu Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Maryland.

12 MAIDEN NAME OF MOTHER Amanda E. Derr.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Elizabeth J. Harris. (Wife).

(Address) 2037. Woodberry Avenue.

15 Filed ..... 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30. 19 27.

17 I HEREBY CERTIFY, That I attended deceased from January 19 27 to April 30 19 27.

that I last saw him alive on apr. 28 19 27.

and that death occurred, on the date stated above, at 4-55. A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/30 1927 (Address) 2220 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. St. Johns, (Leisters Carroll Co

DATE OF BURIAL May 2/1927.

20 UNDERTAKER [illegible] Haller Sons

ADDRESS 3307 Paine St.

MAY 1 - 1927 C. HAYES JONES M.D. Registrar

Per [illegible]

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21761

CERTIFICATE OF DEATH

11-007

E 21761

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 S. 4th St St., 10 Ward 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy S. Struzinska

(a) RESIDENCE NO. 716 S. 4th St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S. if of foreign birth — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 22-1926

7 AGE: Years 8 Months — Days 7 IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Joseph Struzinski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Dobrowolska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Julia Struzinska

(Address) 716 S. 4th St

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-24, 1927 to 4-29, 1927

that I last saw her alive on 4-29, 1927

and that death occurred, on the date stated above, at 6-40 p.m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 2 da.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. mos. 3 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frederick Zapp M. D.

(Address) 4-30 27 800 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

Date of Burial: 5-2 1927

20 UNDERTAKER: Stephen J. Galkowski

ADDRESS: 1000 Hanover

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21762

CERTIFICATE OF DEATH.

90

REGISTERED E 21762

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 12-50 Ward)

2-FULL NAME Kolenill Korneychuk

(a) RESIDENCE NO. 2340 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~ 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant John A Zell

(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

AV 1 - 1927 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arrhythmia Cordis

(duration) yrs. mos. ds. Probably Valv. dis. heart

CONTRIBUTORY (Secondary) Accident

(duration) yrs. mos. ds.

Apr 30 (Signed) W. F. Riley M. D. Coroner

, 1927 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Cemetery Date of Burial May 1 1927

UNDERTAKER John A. Grebbrauckas Jr. ADDRESS 423 S. Paca St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84

E 21763

REGISTERED No. E 21763

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 S. Broadway St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Pikarski

(a) RESIDENCE NO. 616 S Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Pikarski

6 DATE OF BIRTH (month, day, and year) March 12/1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer 0

9 BIRTHPLACE (city or town).....

(State or country) Germany

PARENTS

10 NAME OF FATHER John Kokowski

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances [illegible]

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Germany

14 Informant Helen Mackos

(Address) 616 S Broadway

15 Filed ..... 19 [illegible] JAMES H. JONES, M. D.

1-1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Fenlon M. D. (Coroner)

4/29 1927 (Address) 702 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Leman Hill Road) Date of Burial May 2 1927

20 UNDERTAKER Wendell Diffel & Son ADDRESS 378 Mon

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21764

CERTIFICATE OF DEATH.

E 21764

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 15-58 Ward)

2-FULL NAME Abraham Tucker

(a) RESIDENCE NO. 4017 Park Heights St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
m	m	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloak mfg

(b) General nature of industry, business, or establishment in which employed (or employer) 0 *5

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Tuchman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Feinglass

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Daisy Tuchman

(Address) 4017 Park Heights

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs, mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) D. T. Feinberg M. D.
(Coroner)

April 30 19 27 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rawdale Date of Burial 5/1 1927

20 UNDERTAKER Jacob Louis ADDRESS 1412 E Baltimore st

very important. See instructions on back of certificate.

MAY - 1927

Spec.—1-10-21—M&T—1500 Bks.

E 21765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21765

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Englewood Road WARD 27-53

2-FULL NAME William Henry Morrow

(a) RESIDENCE NO. 1 Englewood Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marian Lee Morrow

6 DATE OF BIRTH (month, day, and year) Nov 6-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Morrow Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George H. Morrow

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Leah A. Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md.

14 Informant Charles A. Morrow (brother)

(Address) 2 Somerset Road.

15 Filed MAY 1 - 1927 H. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1927

17 I HEREBY CERTIFY, That I attended deceased from 1923 to Apr 29 1927

that I last saw him alive on Apr 29 1927.

and that death occurred, on the date stated above, at 11:42 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis - Diabetes Mellitus (duration) yrs 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam etc

(Signed) Alan C. Sutton M. D.

Apr 29. 1927 (Address) 9 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL May 2 1927

UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Balto St

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21766

CERTIFICATE OF DEATH

E 21766

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Alex. F Wickstrom

(a) RESIDENCE NO. Oakland, Nebraska St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Alex. F Wickstrom

6 DATE OF BIRTH (month, day, and year): Aug 12 1873

7 AGE: Years 54 (53) Months 8 Days 20 (18) IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Peter Wickstrom

11 BIRTHPLACE OF FATHER (City or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Elizabeth Sieverson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Mrs Alex F Wickstrom

(Address): Oakland Nebraska

15 Filed MAY 1 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 30, 1927, that I last saw h[illegible] alive on April 30, 1927, and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Contusion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Nebraska

Did an operation precede death? Yes Date of April 16 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Raymond L Johnston, M. D.

4/30, 1927 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Nebraska — Date of Burial: May 1st 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Eks.

E 21767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 21767

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 620 Mulberry St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lynn

(a) RESIDENCE NO. 620 Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) DEC 24 26

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
—	—	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER Walter Lynn

11 BIRTHPLACE OF FATHER (City or town) Balt.

(State or country)

12 MAIDEN NAME OF MOTHER Lily Stanford

13 BIRTHPLACE OF MOTHER (city or town) Balt.

(State or country)

14 Informant Walter Lynn

(Address) 620 W. Mulberry St

15 Filed MAY 1 - 1927 Per R.A.

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1927, to Apr. 29, 1927, that I last saw her alive on Apr. 29, 1927, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David E. Fagnant M. D.

April 30 1927 (Address) 1006 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial May 1/27

20 UNDERTAKER Daniel Easton ADDRESS Govans 916

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21768 — 90 E 21768

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 710 Haw St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Clara Otto

(a) RESIDENCE NO. 710 Haw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married, Widowed, or~~ Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Martin Otto

6 DATE OF BIRTH (month, day, and year): July 24-1855

7 AGE: 71 Years 9 Months 6 Days — IF LESS than 1 day ... hrs. or ... min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 27

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER: Henry Kimmel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Martin Otto

(Address) 710 Haw St

15 Filed MAY 1 - 1927 — C. HAVEN JONES, M. D. Registrar

Per P.M.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to April 30, 1927, that I last saw her alive on April 29, 1927, and that death occurred, on the date stated above, at 6.08 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Dis.

(duration) yrs. 16 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Wadsworth, M. D.

4/30 1927 (Address) 642 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk. Cemetery — Date of Burial 5/2/27

20 UNDERTAKER: Geo Leimbach & Son — ADDRESS 525 N. Eutaw St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21769 E 21769

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1213 Winchester St. 16-23 (WARD)

2-FULL NAME Hannah Elizabeth Johnson

(a) RESIDENCE NO. 1213 Winchester ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W. Johnson

6 DATE OF BIRTH (month, day, and year) Feb. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md. Maryland

PARENTS

10 NAME OF FATHER Edward Wicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Maryland

12 MAIDEN NAME OF MOTHER Betsy E. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Maryland

14 Informant (Address) William Johnson 1213 Winchester

15 Filed MAY 1 - 1927 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28- 1927

17

I HEREBY CERTIFY, That I attended deceased from 4-22- 1927 to 4-28- 1927

that I last saw her alive on 4-28- 1927

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) John E. F. Campbell M. D.

19 (Address) 1403 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 5/1/27

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1634 Druid Hill Ave

E. HAS... R. JONES, M.D. Registrar

for

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21770 — 136 — E 21770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital 27-53 ST. (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Landes

(a) RESIDENCE NO. 71 Bellevieu ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Landes

6 DATE OF BIRTH (month, day, and year): April 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer): B & O Ry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Noah Landes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Belinda Skelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mrs. Catherine Landes 71 Bellevieu ave

15 Filed MAY 1 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1927, to April 29, 1927, that I last saw h alive on April 29, 1927, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Hydrocele operation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 26, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank D Lynn, M. D.

, 19 (Address) 41 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: May 3, 19 2

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Fall Rd

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21771

CERTIFICATE OF DEATH.

90 E 21771
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 Sycamore Ave St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Miles

(a) Residence No. 1311 Sycamore Av St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Miles

6-DATE OF BIRTH (month, day and year): July 1st, 1881

7-AGE, 45 yrs. 9 mos. 24 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of Industry, business, or establishment in which employed (or employer): 0
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Georg. Grimes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Alice McKenney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Mr. William H. Miles
(Address): 1311 Sycamore Ave

15-
Filed ..... 192 .....
Registrar.
Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 29, 1927

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1926 to April 29 1927
that I last saw h[illegible] alive on April 29, 1927
and that death occurred, on the date stated above, at 7 42 m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis, Chronic Fibroid
Phthisis,
(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral insufficiency
(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) J. H. Darby M. D.
, 19 (Address) 1301 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 2 1927

20-UNDERTAKER: A. S. Marshall — ADDRESS: 3539 Fall Rd

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21772

CERTIFICATE OF DEATH.

86-001

REGISTERED NO. E 21772

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 26-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Wiest

(a) RESIDENCE NO. 3428 Mt Pleasant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 1912

7 AGE 15 Years	Months	Days 23	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Schoool

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Milton Wiest

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Elsie Kenny

13 BIRTHPEACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Elsie Hoffman

(Address) 3428 Mount Pleasant

15 Filed MAY 1 - 1927 By [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29 1927.

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 1927, to Apr 29, 1927, that I last saw h~~im~~ alive on Apr 29, 1927, and that death occurred, on the date stated above, at 5-15 ~~pm~~ m.

The CAUSE OF DEATH* was as follows:

Acute Otitis Media (purulent)

(duration) yrs. mos 14 ds.

CONTRIBUTORY Pneumonia (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted, if not at place of death? ~~Home~~ at Home

Did an operation precede death? no Date of

Was there an autopsy? no -

What test confirmed diagnosis? Clinical + Labratory.

(Signed) Clement K. Fellows, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL May 2 1927

20 UNDERTAKER D. Fonticchio ADDRESS 2008 Eden

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21773

REGISTERED NO. 199 E 21773

1-PLACE OF DEATH

City of BALTIMORE: (No. 1687 Darley Ave St. 9-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie M. Siebert

(a) RESIDENCE NO. 1687 Darley Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R. Siebert

6 DATE OF BIRTH (month, day, and year) Jan 15/1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Herman Mielke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Hilda Albrecht

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Wm R. Siebert

(Address) 1687 Darley Ave

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Abortion- self induced

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Wilson M. D.

(Coroner)

5/1/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial May 1 1927

20 UNDERTAKER John Merrick ADDRESS 2008 Pleasant

very important. See instructions on back of certificate. [illegible] CAUSE STATEMENT OF OCCUPATION IS

MAY 1 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~2023~~ 98 ~~E~~ 21774 — X 131 E 21774

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOS St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Kapper

(a) RESIDENCE NO. 713 N. Broadway St. _____ Ward _____ Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____ m.

6 DATE OF BIRTH (month, day, and year) ~~6~~ 2 1889

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
38 37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Greece

(State or country)

PARENTS

10 NAME OF FATHER Theodore Kapper

11 BIRTHPLACE OF FATHER (city or town) Greece

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant Friend

(Address) JOHNS HOPKINS HOS

15 Filed _____, 19____ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1927, to April 29, 1927, that I last saw h.. alive on April 29, 1927, and that death occurred, on the date stated above, at 8 09 m.

The CAUSE OF DEATH* was as follows:

Septicemia

Staphylococcus pyogenes aureus

(duration) ____ yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma in Stomach

(duration) 5 yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? Ohio

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? _____

(Signed) W Palmer, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Steubenville Ohio — Date of Burial May 2 1927

20 UNDERTAKER Hughes & Jones Inc — ADDRESS 434 N. Broadway

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 E 21775

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 76-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harris

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80+			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 10 07

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 BALTIMORE CITY HOSPITALS Informant

(Address) [redacted]

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to April 29, 1927, that I last saw h[illegible] alive on April 28, 1927, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lunt, M. D.

April 29 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 5/2 1927

20 UNDERTAKER J J Fahey Sons — ADDRESS 1518 Light St

[illegible] 1927 — [illegible] HAMILTON JONES, M. D. — Per [illegible] Registrar

Spec.—12-9-25—A Co.—200 Bks.

E 21776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

E 21776

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Stubbood.

(a) RESIDENCE NO. Balto City Hospital St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sol[illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) 0+0

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant City Hospital Records

(Address)

15 Filed MAY 1 - 1927 Registrar C. HAMILTON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927 to April 27, 1927

that I last saw him alive on April 27, 1927

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(duration) Unknown mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam X Ray

What test confirmed diagnosis?

(Signed) R. Blume M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Baden Hearse

Date of Burial 5/2 1927

20 UNDERTAKER J Fahey Sons

ADDRESS 10 E. Eight St

very important. See instructions on back of certificates.

...ENT OF OCCUPATION IS

Spec.—12-9-25—A Co.—200 Bks.

902518

E 21777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+100-001 E 21777

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSP

City of BALTIMORE: (No. _____ St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Gingher

(a) RESIDENCE NO. 202 E. St. Spaniss St. Pt - Ward Inc -

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-22-26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Inc -

(State or country) Lancaster Pa

PARENTS

10 NAME OF FATHER John Gingher

11 BIRTHPLACE OF FATHER (city or town) Pa -

(State or country) Curtain Centre Co Pa

12 MAIDEN NAME OF MOTHER Stella Nickel

13 BIRTHPLACE OF MOTHER (city or town) Pa -

(State or country) Lancaster Pa

14 Informant Records -

(Address) JOHNS HOPKINS HOSP

15 Filed MAY 1 - 1927 C. HAMILTON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1927, to April 30, 1927, that I last saw h[illegible] alive on Apr 30, 1927, and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) —yrs. —mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Lawn, Lancaster Pa Date of Burial May 2. 27

20 UNDERTAKER: John F Denny ADDRESS: 715 Light St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E21778 HEALTH DEPARTMENT—CITY OF BALTIMORE 21778

CERTIFICATE OF DEATH. 90 E 21778

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 936 Druid Hill Ave ST. 17-24 WARD)

2-FULL NAME James F. Murray

(a) RESIDENCE No. 936 Druid Hill Ave ST.— WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Jan 7. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	49	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Alice Murray

(Address) 936 Dr Hill Ave

15 Filed MAY 1 1927 19 C. HARRISON JONES, M. D. Registrar

Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1925, to Apr 28, 1927,

that I last saw h alive on 4/28, 1927,

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows: ~~1~~

Angina Pectoris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Organic heart disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

4/29. 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 2 1927

20 UNDERTAKER Geo. M. Johnson

ADDRESS 1234 Eutaw St

ATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21779

CERTIFICATE OF DEATH.

124 E 21779

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward

2-FULL NAME Mrs. Jamie E. Tuesdale

(a) RESIDENCE NO. 2416 N. Calvert St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Tuesdale

6 DATE OF BIRTH (month, day, and year) Mar 31 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	1	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore md

PARENTS

10 NAME OF FATHER Adam Fuesberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Abigail Bowman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant

(Address) 2416 N. Calvert St.

Filed MAY 1 - 1927 H. M. JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 18 19 27 to April 30 19 27,

and I last saw h.. alive on April 30 19 27,

and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

If Where was disease contracted if not at place of death? In Hospital where she had removed

Did an operation precede death? Yes Date of March 23, 1927

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Vernon N. Norwood M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Cem May 3 1927

20 UNDERTAKER — ADDRESS

Jos Loudon & Son 207 S. Pac

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

21780

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21780

CERTIFICATE OF DEATH

464 78

E 21780

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4705 Wayne Av St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel M. Richer

(a) RESIDENCE NO. 4705 Wayne Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. O. R. Road

9 BIRTHPLACE (city or town)

(State or country) Pa

PARENTS

10 NAME OF FATHER Aaron M. Richer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Dora B. McGuthrie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Va

14 Informant Mrs Dora B. Richer

(Address) 4702 Wayne Ave

15 Filed ____, 19__ ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ___ death on the day stated above.

The CAUSE OF DEATH* was as follows: Convulsions due to Epilepsy for several years"

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Hennessy, M. D.

(Coroner)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg West Va May 2 1927 Date of Burial

20 UNDERTAKER for Loerdels Son ADDRESS 217 S. Paca

very important. See instructions on back of certificate.

Cor.—12-9-25—A. Co.—200 Bks.

21781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21781

185 E 21781

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 1726 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward D. Dellard

(a) RESIDENCE NO. 508 Clinton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mella Dellard

6 DATE OF BIRTH (month, day, and year) July 4, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) O.D.

(c) Name of employer

9 BIRTHPLACE (city or town) Pa (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mella Dellard (Address) 508 Clinton Ave

15 Filed ..... 19..... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull (accidental) Oct. 7, 1924

Pneumonia (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

(Signed) J. J. Kenney M. D. (Coroner)

April 30 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State yrs.. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mays Ville Frederick Co Md 5/2 1927

20 UNDERTAKER ADDRESS

Robert Brooks & Son Baltimore Md

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21782

CERTIFICATE OF DEATH.

148

E 21782

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. (St.) Hosp (Ward) 9016

2-FULL NAME Mrs Hazel M Emick

(a) RESIDENCE NO. 2516 W. Baltimore St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred - yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/9/1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Wiesner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lily Brody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Wst Balt. Gen. Hosp Resd

15 Filed MAY 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/1927

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1927, to 5/1, 1927,

that I last saw her alive on 5/1, 1927,

and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Acute)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/29/27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Arnold F Jones, M. D.

5/1, 1927 (Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 5/4 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

THOSE LEVYING IMPORTANT See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-12-23—M&T—5000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21783

CERTIFICATE OF DEATH.

E 21783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. Gen. Hosp. (St.) 20-69 (WARD) 161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 2516-W Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: White

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/29/27

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hazel Kiessner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) W B.G. Hosp. Balto

15 Filed MAY 2 - 1927, 19 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1927, to 4/30, 1927, that I last saw him alive on 4/30, 1927, and that death occurred, on the date stated above, at 4 10 a. m.

The CAUSE OF DEATH* was as follows:

Eclampsia toxemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Premature birth (7 mos)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Charles L. Jones, M. D.

4/30, 1927 (Address) West Balt Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 5/1 1927

20 UNDERTAKER: Robert Booth & Son

ADDRESS: Balto

HOW IS VERY important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21784

E 21784

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH

REGISTERED NO. 23-32

City of BALTIMORE: (No. 1307 Clarkson St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard F. Harvey

(a) RESIDENCE NO. 1307 Clarkson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) April, 1, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
		1.	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. dnd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Robert H. Harvey.

11 BIRTHPLACE OF FATHER (City or town) Toronto, Canada.

(State or country)

12 MAIDEN NAME OF MOTHER Marie V. Hagen.

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant Robert H. Harvey.

(Address) 1307 Clarkson St.

15 Filed MAY 2 - 1927 C. Hartman Jones M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 30 19 27, to May 1 19 27.

that I last saw h[illegible] alive on April 30 19 27.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Toxemia

(Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Mitchell M. D.

May 1 19 27 (Address) 1179 Hilliard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Wave, Md. Date of Burial 19

20 UNDERTAKER C. Howard Evans ADDRESS 32 Hilliard St.

Be certain to print legibly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

PLACE OF DEATH E 21785 Ridge Road - Hill Top

REGISTERED NO. E 21785

CITY OF BALTIMORE: (No. Mount Washington ST. 27-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith R. Powell

(a) RESIDENCE NO. Mount Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 2, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	9 3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel W. Powell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida M. Reese

13 BIRTHPLACE OF MOTHER (city or town) Cleveland (State or country) Ohio

14 Informant Daniel W. Powell (Address) Mount Washington

Filed 5-2 1927 19 HARRY C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 29, 1927, that I last saw h[illegible] alive on April 28, 1927, and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Chorea, Chr. Myocarditis, Chr. Endocarditis Tricuspid Insufficiency, Mitral & Aortic Insufficiency, Chr. Lt. Nephritis

(duration) 2+ yrs. mos ds.

CONTRIBUTORY (Secondary) [illegible] Carolina Diabetes

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. W. Bishop, M. D.

Apr 30, 1927 (Address) 581 Sheldon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	5/2 1927

UNDERTAKER Henry H. Mears & Emerson H. Calvert ADDRESS

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21786

CERTIFICATE OF DEATH

E 21786

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 S. Eden St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Fine

(a) RESIDENCE NO. 104 S. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 68 — Months: — — Days: — — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Meyer Fine
(Address) 2604 Baker st

15 Filed MAY 2 - 1927 19 C. HAMILTON JONES, M. D. Registrar
Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927 to April 30 1927
that I last saw h~~im~~ alive on April 25, 1927
and that death occurred, on the date stated above, at 3 30 P. M.

The CAUSE OF DEATH* was as follows:

Papillary Carcinoma of Bladder
Coma

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Metastases

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted
If not at place of death? Not to infectious
Did an operation precede death? Yes Date of Dec. 1926
Was there an autopsy? No
What test confirmed diagnosis? Operation + Cystoscopy

(Signed) Isabelle A. Levy, M. D.
4-30-1927 (Address) 913 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — Date of Burial: May 2 1927

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 711 E Balto St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

E 21787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Rayon and Dukeland (ST.) 14 (WARD)

Married

2-FULL NAME Menica Goodman

(a) RESIDENCE NO. 1207 W. Nath Ave ST. ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Eva Goodman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 38 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker 103

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Etta Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Eva Goodman

(Address): 1207 W Nath Ave

15 Filed MAY 2 - 1927 By ..... C. HAMPTON HOLMES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/1/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1927, to 5/1, 1927

that I last saw him alive on 5/1, 1927

and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary): Acute anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

5/1, 1927 (Address) M G J. H.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Chapel — DATE OF BURIAL: 5/2 1927

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21788

CERTIFICATE OF DEATH.

11-002

E 21788

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

City of BALTIMORE: (No. 15-58 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Altschul

(a) RESIDENCE NO. 2436 Reynolds Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE: Years 11 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Louis Altschul

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Helen Good

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital

(Address)

15 Filed ..... 19.. H. A. [illegible] JONES, M. D. Registrar

Per W.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to May 2nd, 1927, that I last saw h.. alive on May 2nd, 1927, and that death occurred, on the date stated above, at 4 20 A m.

The CAUSE OF DEATH* was as follows:

Septic meningitis

(duration) x yrs. x mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

over

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms - Laboratory Test

(Signed) John A. Aspen, M. D.

5/2, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Workmen's Cem. Date of Burial 5/4 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1129 E Oliver St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21789

CERTIFICATE OF DEATH.

129 E 21789

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1908 W. North Ave. St. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Anna Hutchinson

(a) RESIDENCE NO. 1908 W. North Ave. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Hutchinson

6 DATE OF BIRTH (month, day, and year): Feb 5 - 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
72	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~ ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Louis P. Reisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Mary E. Dacy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs. Clara Hutchinson 1908 W North Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1927, to Apr 30, 1927.

that I last saw h[illegible] alive on Apr 29, 1927

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - 5 yrs?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Hurlearty, M. D.

(Address) 837 W Preston St.

Apr 30 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 2 1927

20 UNDERTAKER: W. J. Hickmott Son — ADDRESS: Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21790

CERTIFICATE OF DEATH.

74001

E 21790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 203 (St.) Carroll (Ward) R127-55

2-FULL NAME Francis J. Willoughby

(a) RESIDENCE NO. 203 ST. Carroll Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada N. Willoughby

6 DATE OF BIRTH (month, day, and year): July 28 1853

7 AGE: Years 73 Months 9 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer: M. J. Grove Lime Co.

9 BIRTHPLACE (city or town) (State or country): Preston Md.

PARENTS

10 NAME OF FATHER: William Willoughby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. E. P. Willoughby

(Address) 3803 Montgomery Ave

15 MAY 2 - 1927 H. J. JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 8th, 1926, to Apl 30th, 1927, that I last saw him alive on Apl 29th, 1927 and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia (one)

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas, M. D.

, 19 (Address) 3043 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: May 2 1927

20 UNDERTAKER: Meckner Bros

ADDRESS: North Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21791

E 21791

CERTIFICATE OF DEATH

45

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. Calvert 1733 rd St 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Matilda C Grothaus

(a) RESIDENCE NO. 3036 Guilford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 20, 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	74	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 071

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo F. Grothaus

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Wessler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant deceased

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to April 30, 1927, that I last saw her alive on April 30, 1927, and that death occurred, on the date stated above, at 7:15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of April 25, 1927

Was there an autopsy? Partial autopsy

What test confirmed diagnosis?

(Signed) F. J. Geraghty M. D.

, 19 (Address) Univ Medical Visit

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Baltimore Cemetery 5/3, 1927

20 UNDERTAKER — ADDRESS

Henry W. Mears & Son 803 N Calvert

MAY 2 - 1927

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21792

CERTIFICATE OF DEATH.

E 21792

101-001

1-PLACE OF DEATH Franklin Sq. Hosp. 21-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Michael Fredericz

(a) RESIDENCE NO. 417 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Flora Fredericz

6 DATE OF BIRTH (month, day, and year) April 20 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~38~~	37	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Michael Fredericz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Irene Kis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Flora Fredericz

(Address) 417 W. West St

15 Filed MAY 2 - 1927 Registrar RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1927, to April 30, 1927, that I last saw him alive on April 30, 1927; and that death occurred, on the date stated above, at 130 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (RR)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph Metsky, M. D.

19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: May 3rd 19

20 UNDERTAKER: E Schlosnitzer

ADDRESS

THIS IS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Nolley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 21793

1-PLACE OF DEATH

REGISTERED E 21793

City of BALTIMORE: (No. 1702 N Dallas St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Nolley

(a) RESIDENCE NO. 1702 N Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Nolley

6 DATE OF BIRTH (month, day, and year): 8-6-1865

7 AGE: Years 62 | Months 8 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Va.

PARENTS

10 NAME OF FATHER: Albert Nolley

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Annie Nolley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Mrs Hattie Nolley

(Address): 1702 N. Dallas

15 Filed ..... 19 C. HAYDEN JONES, M. D.

MAY 2 - 1927 Per R.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 21 1927, to April 29, 1927, that I last saw h alive on April 29, 1927, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Cardiac Insufficiency

(duration) ? yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Septicemia

Furuncle (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted

If not at place of death! Unknown

Did an operation precede death! no Date of no

Was there an autopsy! no

What test confirmed diagnosis! Physical Exam

(Signed) L. F. Hall, M. D.

, 19 (Address) 426 E 23 d St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem. Date of Burial: May 2 19 27

20 UNDERTAKER: Mrs J. G. Locke ADDRESS: 1302 Jefferson

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21794 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21794

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 202 Hillen Road ST., 9-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Milton Jones

(a) RESIDENCE No 202 Hillen Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 28th 1926

7 AGE — Years: — Months: 4 Days: 2 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Melvin Jones

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Coleman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Melvin Jones (Address) 202 Hillen Road

15 Filed 4-1927 C. HAMILTON JONES, M. D. Registrar

Per K J

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18 1927 to April 30 1927 that I last saw him alive on April 30 1927 and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis (duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E Jones, M. D.

, 19 (Address) 1425 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery DATE OF BURIAL May 2 1927

UNDERTAKER Frederick Lobaugh & Sons ADDRESS Fulleton

TION IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 21795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 21795

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 27-53 (Street)

2-FULL NAME Robt Lee Davis

(a) RESIDENCE NO. 1 Roland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 30/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... gd

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Stuart E. Davis

11 BIRTHPLACE OF FATHER (city or town)..... Va.

(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Arninger

13 BIRTHPLACE OF MOTHER (city or town)..... Md.

(State or country)

14 Informant Stuart E. Davis

(Address) 1 Roland Ave

15 Filed ..... 19 C. EDWARD JONES, M. D.

MAY 2 - 1927 Per L.L. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

May 1/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Calvin, M. D.
(Coroner)

5/1/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgewood Ridge Date of Burial May 2 1927

20 UNDERTAKER Horace F. Burgee ADDRESS 3123 Falls Rd.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E21796-

HEALTH DEPARTMENT—CITY OF BALTIMORE

E21796-

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 N. Eden St 10-14 Ward)

2-FULL NAME Domenico Pistorio

(a) RESIDENCE NO. 1212 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29. 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retires

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Salvatore Pistorio

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Tomasa Mancioni

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Antonino Pistorio

(Address) 1212 N. Eden St.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to ....., 19.....,

that I last saw him alive on April 30, 1927,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Isadore N. Peters, M. D.

Jan 17, 1927 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — Date of Burial: 5/3 1927

20 UNDERTAKER: Geo J Ruth — ADDRESS: 1735 Harford Ave

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21797

91-007

CERTIFICATE OF DEATH

E 21797

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2509 St Paul St. 12-50 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Cecelia Neary

(a) RESIDENCE NO. 2509 St. Paul St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J Neary

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Kane

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Naughton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Anna Neary

(Address) 2509 St. Paul St

Filed MAY 2 - 1927 19 H. [illegible] Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1- 1926 to May 1 1927

that I last saw her alive on May 1 1927

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) I Sw Gaddess M. D.

4/2/27 19 (Address) 321-E-25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: May 4 1927

20 UNDERTAKER: Chas P. Kraus & Son — ADDRESS: 118 West Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21798

CERTIFICATE OF DEATH

31

REGISTERED NO. E 21798

1-PLACE OF DEATH

City of BALTIMORE: (No. 729 So. Broadway St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ALEXANDER GIBOWICZ,

(a) RESIDENCE NO. 729 So. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Apolonia Gibowicz,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Paul Gibowicz,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown,

14 Informant Mrs. Apolonia Gibowicz, Wife

(Address) 729 So. Broadway

15 Filed MAY 2 - 1927 19 H. M. Jones M. D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25 1927 to Apr. 30 1927

that I last saw h alive on Apr. 29 1927

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Days or Hours (doration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Hamilton Greene M. D.

Apr 30. 1927 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. Date of Burial May 3- 1927

20 UNDERTAKER W. J. Sadowski. ADDRESS 905 S. Ann St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21799

HEALTH DEPARTMENT—CITY OF BALTIMORE

172-001

E 21799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Portland St. 21-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel S. Leonard

(a) RESIDENCE NO. 718 Portland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Lenard

6 DATE OF BIRTH (month, day, and year) July 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bottling Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Thos. Brodnax (Address) 718 Portland St

15 Filed 12 — 1927, 19 C. HAMPSON JONES, M. D. (Registrar) Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1927, to Dec, 1927,

that I last saw h— alive on Dec, 1927,

and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebrosis & Senility (Acute)

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

12/1, 1927 (Address) 617 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Dec 31 1927

20 UNDERTAKER H. A. Strauss & Sons — ADDRESS 703 Hamp

Spec.—1-12-23—M&T—500 Bks.

E21800 HEALTH DEPARTMENT—CITY OF BALTIMORE E21800

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 378 Forrest St. 5-8 WARD)

2-FULL NAME Giuseppe Cottone

(a) RESIDENCE NO. 378 Forrest ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs Vicenzina Cottone

6 DATE OF BIRTH (month, day, and year) Jan 14-1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
42 yrs	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of Industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Domenico Cottone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Josephine Sedavista

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Charles Silvestri

(Address) 378 Forrest St

15 Filed MAY 2 1927 H. [illegible] JONES, M.D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1927, to May 1, 1927, that I last saw him alive on May 1, 1927 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S. DiStefano M. D.

May 2, 1927 (Address) 407 N. Peters St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent Cemetery

DATE OF BURIAL: 5/3 1927

20 UNDERTAKER: Geo J Ruth

ADDRESS 1735 Harford Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21301

REGISTERED NO. 77 E 21301

PLACE OF DEATH Balto City Hospts.

City of BALTIMORE: (No. Balto. Md St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Frazier

(a) RESIDENCE NO. 930 N. Howard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred each yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE: Years 25 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Painter Va

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospts.

(Address) Balto Md.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 4-29 27

17 I HEREBY CERTIFY, That I attended deceased from 4-9- 19 27, to 4-29 19 27,

that I last saw h[illegible] alive on 4-29 19 27,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH was as follows: Cardiac Failure - Toxic Delirium

(duration) yrs. mos. Days

CONTRIBUTORY (Secondary) Manic Depressive Psy. - Chronic Manic Phase

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) Harry H. Edmunds M.D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial 5/2 1927

20 UNDERTAKER: Samuel A. Brasley & W. Biddle ADDRESS W. 78

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Purvey.

E 21802

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 21802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Division St. 1724 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Purvey.

(a) RESIDENCE NO. 1305 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Purvey

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE 42 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER James Grad

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Diana Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Charles Purvey
(Address) 1305 Division St

15 Filed MAY 2 - 1927 H. M. JONES, M. D. Registrar

By RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20 1927 to May 1 1927 that I last saw her alive on Apr. 30 1927 and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Carr Jr. M. D.

May 2 1927 (Address) 515 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Cemetery

DATE OF BURIAL 5-4 1927

UNDERTAKER Wm E. A. Gibson

ADDRESS 1735 Harlem Ave

TION is very important. See instructions on back of certificates.

Troup.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21803

E 21803

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2620 Huntington St. Ward 12-51

2-FULL NAME Wm. Curtis Troup

(a) RESIDENCE NO. 2620 Huntington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bell Hart

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locomotive Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. R. R. Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Troup

11 BIRTHPLACE OF FATHER (City or town) New York

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Rose Maney

13 BIRTHPLACE OF MOTHER (city or town) New York

(State or country) Pa

14 Informant Wm. Troup

(Address) 2620 W. Huntington St.

15 Filed APR 2 - 1927 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to April 30, 1927, that I last saw him alive on April 29, 1927, and that death occurred, on the date stated above, at 1488 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Gall bladder disease (2 yrs)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease of heart

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. E. DeMagnes M. D.

4/30, 19 27 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

Date of Burial 5/3/27

20 UNDERTAKER Gr. Weber & Son ADDRESS 2503 Edmondson Ave

very important. See instructions on back of certificates.

Last statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 21804

CERTIFICATE OF DEATH.

E 21804

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2728 Edmondson ave St. 6-69 Ward)

2-FULL NAME Vera Marquette Carruthers

(a) RESIDENCE NO. 2728 Edmondson ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 5/22

7 AGE: Years 4 | Months 7 | Days 26 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER: Richard P. Carruthers

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER: Vera M. Taylor

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: Richard P. Carruthers

(Address) 2728 Edmondson ave

15 Filed ..... 19..... Per ..... Registrar .....

C. HAMILTON JONES, M. D.

MAY 2 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to May 1, 1927, that I last saw her alive on April 30, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

1 Bronchial Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) Henry C. Parker, M. D.

, 19 (Address) 1202 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laudon-Park Date of Burial: May 3 1927

20 UNDERTAKER: John Ortwein

ADDRESS: 1900 Eutaw Place

very important. See instructions on back of certificate.

Spec.--1-12-23—M&T—500 Bks.

E 21805 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 E 21805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor M. Kreesen (Kreeson)

(a) RESIDENCE NO. Home for Incurables ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-14-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	-3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Isaiah Kreesen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Cornelia G. Rector

(Address) Hilton Manhattan Apts

15 Filed May 4 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927 to May 1" 1927

that I last saw her alive on May 1, 1927

and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) Wm Bruce M. D.

5/2 1927 (Address) Latrobe Apts - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greene Mount May 4 1927

20 UNDERTAKER ADDRESS

Jno Crutchfield 1200 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

E 21806 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 21806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Milton a St. 8-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Pozderosky

(a) RESIDENCE No. 1406 Milton a St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Pozderosky

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Pozderosky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant John Pozderosky

(Address) 1406 Milton a

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17. 1927, to April 30. 1927, that I last saw him alive on April 30. 1927 and that death occurred, on the date stated above, at 1205A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Cardiac Trouble

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur Reynolds M.D.

April 30. 1927 (Address) 801 Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 3 1927

20 UNDERTAKER Frank Ecker & Son — ADDRESS 1166 Monroe

FOR A VERY important SEE instructions ON BACK OF CERTIFICATE.

Cor.—12-9-25—A Co.—200 Bks.

E 21807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 21807

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 43 E. Montgomery St St. 22-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie G. Linthicum.

(a) RESIDENCE NO. 43 E. Montgomery St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Charles M. Linthicum.

6 DATE OF BIRTH (month, day, and year): January 19, 1863

7 AGE

Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
64	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harris Forbes.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Annie Grafton.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore, Md

14 Informant Daisy Elliott (daughter)

(Address) 43 E. Montgomery St.

15 Filed MAY 2 - 1927 Per K.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Edward Fenniman M. D.

(Coroner)

5/2 · 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial: May 3 1927

20 UNDERTAKER: John H. Deeny ADDRESS: 7 Eight St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 641 Wayne ST., 22-30 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Torrence

(a) RESIDENCE No. 641 Wayne ST., 22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widow

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah Turner

6 DATE OF BIRTH (month, day, and year) 11/10/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper in dairy 023

(b) General nature of industry, business, or establishment in which employed (or employer) Car Dept.

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Salisbury N.C.

PARENTS

10 NAME OF FATHER James McCorkle

11 BIRTHPLACE OF FATHER (city or town) Salis (State or country) bury N.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Salisbury (State or country) N.C.

14 Informant Sarah Turner (Address) 641 Wayne Ave

15 Filed MAY 2 - 1927, 19... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/1927

17 I HEREBY CERTIFY, That I attended deceased from 4/13/1927, to 4/30/1927, that I last saw him alive on 4/29/1927, and that death occurred, on the date stated above, at 1.20 m.

The CAUSE OF DEATH* was as follows:

Peritonitis; and septicemia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) (a) Ulcer of the Stomach

(b) Ulcer of Duodenum (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/7/27

Was there an autopsy? no

What test confirmed diagnosis? Physical & History

(Signed) Wm. Bishop, M. D.

, 19 (Address) 759 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL May 3 19 27

20 UNDERTAKER J. A. Brown's Son — ADDRESS 1080 W. Pratt

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21809

CERTIFICATE OF DEATH.

11-002

E 21809

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 N Bentalou St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philippina A Schmidt

(a) RESIDENCE NO. 1725 N Bentalou St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Schmidt

6 DATE OF BIRTH (month, day, and year) Oct 11 57

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Steinbach

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Charles Schmidt

(Address) 1725 N Bentalou St.

MAY 2 - 1927 BALTIMORE, MD.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 18th, 1927, to apl 29th, 1927, that I last saw her alive on apl 29th, 1927, and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Influenza

(duration) — yrs. 3 mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

— (duration) — yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Examination & Symptoms

(Signed) Edward Endlich M. D.

April 30th, 1927 (Address) 1339 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

Date of Burial May 2 1927

20 UNDERTAKER H M Moulton

ADDRESS 2237 W North.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21810

CERTIFICATE OF DEATH.

+ 188-003

E 21810
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 6-9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Ralph H. Bergstresser

(a) RESIDENCE NO. 55 Frederick St. Hanover, Pa Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Bergstresser

6 DATE OF BIRTH (month, day, and year): Jan 2/1882

7 AGE — Years: 45 — Months: 3 — Days: 30 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergeman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):
(State or country): Pa.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Pa

14 Informant: Mr. Austin Thomas
(Address): Hanover, Pa

15 Filed ..... 19 ..... Registrar

MAY 2 - 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture 9th thoracic vertebr & severed spinal cord. Automobile which he was driving skidded & turned over near York, Pa on Apr 5/27

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Bates M. D.
(Coroner)

5/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanover Pa — Date of Burial: May 4 1927

20 UNDERTAKER: Jos Forsaken & Son — ADDRESS: 217 S. Paca St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21811

CERTIFICATE OF DEATH.

E 21811

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 21-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thomas -

(a) RESIDENCE NO. 1422 Ward St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, ~~Married~~ ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Washington D. C.

(State or country)

PARENTS

10 NAME OF FATHER: Willie Thomas -

11 BIRTHPLACE OF FATHER (city or town)

(State or country): D. C.

12 MAIDEN NAME OF MOTHER: Anna -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): D. C.

14 Informant: Martha Thomas

(Address): 1422 Ward st.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April. 28, 27

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to April. 28, 1927

that I last saw her alive on April. 28, 1927

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Cervix.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) ..... yrs. ..... mos. 3 ds.

Is Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. E. Caldwell, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery Date of Burial May 2 1927

20 UNDERTAKER: Walter Spriggs ADDRESS 139 W. Hamburg st

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21812

CERTIFICATE OF DEATH.

111-001

E 21812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 35 ST. WARD)

2-FULL NAME Emma Gitzen

(a) RESIDENCE NO. 1410 E. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1873

7 AGE: Years 53 | Months 6 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Adam Gitzen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Schoshuer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Hosp. Record.

15 Filed MAY 2 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1927

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1927, to April 30, 1927,

that I last saw h ER alive on April 30, 1927,

and that death occurred, on the date stated above, at 12 10 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 3/28/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 5/2/1927

20 UNDERTAKER: E. O. Fanning & Son - 1938 E — ADDRESS: Lafayette ave.

Per K.M.C.

TION is very important. See instructions on back of certificates.

...ecessary to prepare, examine, file and preserve. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21813

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

16-67 90

E 21813

REGISTERED NO.

City of BALTIMORE: (No. 2903 Brighton St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Ann Dampman

(a) RESIDENCE NO. 2903 Brighton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jonas Dampman

6 DATE OF BIRTH (month, day, and year): Sept. 3rd 1846

7 AGE: Years 80 | Months 8 | Days 27 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Columbus

(State or country): Ohio

PARENTS

10 NAME OF FATHER: Wm. Stout

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa.

12 MAIDEN NAME OF MOTHER: Puffenberger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mrs. Chas. Craft

(Address): 2903 Brighton St.

15 Filed MAY 2 - 1927 19

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30th 1927

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to April 30th, 1927, that I last saw h[illegible] alive on April 27, 1927, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Cortical Degeneration and Senility

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Robert E. Craft, M. D.

5-2-1927 (Address) 3048 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Govanstown Presbyterian Cemetery

Date of Burial: 5/3/1927

20 UNDERTAKER: E. J. Fanning & Son - 1938 E. Lafayette Ave.

ADDRESS

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21814

CERTIFICATE OF DEATH.

113 E 21814

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 Bruce St. St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. W. K. Duffey

(a) RESIDENCE NO. 512 Bruce St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 11, 1927.

7 AGE: Years 17 Months Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER Garland Gaskins

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Duffey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant Eliza Duffey

(Address) 512 Bruce St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) no history of any other disease

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

11/29 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY Date of Burial MAY 2 - 1927 19

20 UNDERTAKER ADDRESS

Now in [illegible] Health.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

21815 E 21815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] 4-30 St., [illegible] Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [illegible]

(a) RESIDENCE NO. [illegible] St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: [illegible] Months: [illegible] Days: [illegible]

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed _____, 19__ HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) [illegible] 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: [illegible]

[illegible] (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) [illegible] M. D. (Coroner)

, 19 2 7 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY — Date of Burial 19

20 UNDERTAKER — ADDRESS

[illegible] MAY 2 192[illegible]

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 21816

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 E 21816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found in Harbor

City of BALTIMORE: (No. Foot of Broadway St 2-4 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Carroll

(a) RESIDENCE NO. unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor ? d/b

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer unknown

9 BIRTHPLACE (city or town).....

(State or country) England

PARENTS

10 NAME OF FATHER Carroll

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) England ?

14 Informant.....

(Address)

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFeeley M. D.

(Coroner)

4/20, 1927 (Address) 702 Chases

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial MAY 2 1927 19

20 UNDERTAKER Commissioner Health ADDRESS

C. BRANCH JOHNSON

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21817

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21817

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH ALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ____ St., 3-5 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Ross

(a) RESIDENCE NO. Sandsberry Alley St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Dunt Ross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Missouri

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Missouri

14 Informant ALTIMORE CITY HOSPITALS

(Address) Records

15 Filed ____ 19 ____ Registrar

1314

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to May 1, 1927, that I last saw h~~im~~ alive on April 30, 1927, and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Emphysema

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) A. Hoopau Lintl, M. D.

May 2 1927 (Address) ALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if death was due to Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

MAY 2 - 1927

Commissioner Health

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21818 49 E 21818

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ritchie

(a) RESIDENCE NO. Balto City Hospital Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cedar Mohr do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N.Y. State

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 19 1313 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-30-27

17

I HEREBY CERTIFY, That I attended deceased from 10-6-, 19 25, to 4-30-, 19 27

that I last saw h[illegible] alive on 4-30-, 19 27

and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Right Arm

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Blaycock M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND
MAY 2 - 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21819

CERTIFICATE OF DEATH.

92 E 21819

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Westwood ave ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Shofsid

(a) RESIDENCE NO. 2110 Westwood ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Shofsid

6 DATE OF BIRTH (month, day, and year) Mch

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Lawhman Shofsid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Etka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Goldie Shofsid

(Address) 2110 Westwood ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1927 Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to May 2nd, 1927, that I last saw h(e) alive on May 2nd, 1927, and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. ... mos 17 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I A Zenker, M. D.

5/2, 1927 (Address) 2020 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levindale Cemetery

DATE OF BURIAL 5/5 1927

20 UNDERTAKER Jack Levy

ADDRESS 1403 Eutaw St

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21820 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21820

CERTIFICATE OF DEATH.

11-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 St. John ST. 27-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. McKee

(a) RESIDENCE NO. 6 Gilham Road (Usual place of abode) Mt Washington STREET Md WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Ida M. McKee

6 DATE OF BIRTH (month, day, and year): May 27 1866

7 AGE: Years 60 Months 11 Days 3 If LESS than 1 day, ... hrs or ... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secy & Treas

(b) General nature of industry, business, or establishment in which employed (or employer): Funeral Director

(c) Name of employer: Henry Jenkins Son Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Francis M. McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna L Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Ida M. McKee

(Address) 6 Gilham Rd Mt Washington

15 Filed May 1 1927 C. HARRISON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to April 30, 1927, that I last saw h— alive on April 29, 1927 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Hal Kerr Sr. M. D.

May 1, 1927 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: May 3 1927

20 UNDERTAKER: Henry Jenkins Son Co — ADDRESS: Eichard McCollch St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21821 E 21821

CERTIFICATE OF DEATH.

NH-002

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Beech Ave Ham 40 ST., WARD 43-52

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Haws Tyson Lindley

(a) RESIDENCE No. Nymans Park Apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Jacob Lindley

6 DATE OF BIRTH (month, day, and year): May 2nd 1867

7 AGE: Years 59; Months 11; Days 29; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: J. Tyson Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Fannie Haws Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Jacob Lindley
(Address): Nymans Park Apt

15 Filed 1927 C. HAMPTON JONES, M. D. Registrar
Per RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1927, to May 1st, 1927, that I last saw her alive on May 1st, 1927, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Arteriosclerosis

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary): Cerebral Thrombosis

(duration) yrs mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. Shotland, M. D.

May 2nd 1927 (Address) 300 N. Carrol St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dellmount Cem

DATE OF BURIAL: May 3rd 1927

20 UNDERTAKER: Henry Jenkins Sons Co

ADDRESS: Cleveland & McCulloh Sts

Spec.–7-17-26—A Co.—200 Bks.

21822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 21822

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2904 Beaver Ward) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Shaffer Amspacher

(a) RESIDENCE NO. 2904 Beaver St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Amspacher

6 DATE OF BIRTH (month, day, and year): Nov 14, 1836

7 AGE: Years 90 Months 5 Days 17 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) York Co. Penna. (State or country)

PARENTS

10 NAME OF FATHER Henry Amspacher

11 BIRTHPLACE OF FATHER (City or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Katherine Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant: Mrs W. L. Burns daughter

(Address) 2904 Beaver Ave

15 Filed May 5 1927 C. HAMILTON JONES, M. D. Registrar

Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15th 1926 to May 1st 1927

that I last saw him alive on April 30 1927

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Leady M. D.

5-1 1927 (Address) 4218 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Cem, New York. Date of Burial May 5 1927

20 UNDERTAKER: Wallace Cook ADDRESS 2218 Eutaw

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Susanna Schorl

E 21823

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21823

91-002

Wards

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4006 Wilson St., 19-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Schorl.

(a) RESIDENCE NO. 4006 Wilson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Christian Schorl

6 DATE OF BIRTH (month, day, and year): 2-8-1845

7 AGE: Years 82. Months 2 Days 30 24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Geo Hrabick

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs Wm Beaton

(Address) 4006 Wilson Ave

15 Filed ..... 19 ..... Registrar

1927

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1926 to May 2 1927

that I last saw h alive on May 1 1927

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Contra Cathenia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Senility

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted: Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Haworth Taylor M. D.

5/2 1927 (Address) 1027 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

Date of Burial: May 4 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 507 E Balto

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Bunkley N.Gr.-Ingram & Rowlett

E 21824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-001

E 21824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1736 Ashburton Ave ST. 15-18 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard P. Fogle

(a) RESIDENCE NO. 1736 Ashburton Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Fogle

6 DATE OF BIRTH (month, day, and year): April 15 1860

7 AGE — Years: 67 — Months: — Days: 14 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Peter Fogle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sarah Brown

14 Informant (Address): Mrs. Walter L. Hillis 1736 Ashburton Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6th, 1927, to Apr. 27, 1927, that I last saw him alive on Apr 27th 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease
Senility

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia -

Terminal Pneumonia -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Murray Kelly M. D.

, 19 (Address) 304 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md. — DATE OF BURIAL: Mar 2 1927

20 UNDERTAKER: H. W. Cole — ADDRESS: 502 E. Fayette

Spec.—1-12-23—M&T—500 Bks.

E 21825

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21825

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 S Hanover ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Dietro~~ Diptina Dezeo.

(a) RESIDENCE No. 1027. S. Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr mos. ds. How long in U. S., if of foreign birth? 1yr yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 23 1926

7 AGE: Years 1 Months 3 4 Days If LESS than day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alexander Dezeo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Helen Pavlers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece.

14 Informant Mrs. Helen. Dezeo.

(Address) 1027 S. Hanover St.

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-30-, 1927, to 5-1-, 1927.

that I last saw h[illegible] alive on 5-1-, 1927

and that death occurred, on the date stated above, at 10.9. m

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) myocarditis —

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Demaco, M. D.

5-2-1927 (Address) 1604 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemty.

DATE OF BURIAL: 5/3 1927

20 UNDERTAKER: Geneyer. L. Ruth.

ADDRESS: 1765 Harford Ave.

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21826

CERTIFICATE OF DEATH

E 21826

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

City of BALTIMORE: (No. 1020 Hillyman St., 10-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Bernstein

(a) RESIDENCE NO. 1020 Hillyman St. Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: Years 82; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant (Address) Baltimore City Hospitals

Filed ..... 19..... Per ..... Registrar

1927 C. BARTON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1. 1927

17

I HEREBY CERTIFY, That I attended deceased from April 19. 1927 to May 1. 1927.

that I last saw h[illegible] alive on May 1. 1927

and that death occurred, on the date stated above, at 8 00 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia Terminal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pty Chronic Nephritis Central Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Findings

(Signed) Harry Feldman, M. D.

1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cmty Date of Burial May 4. 1927

20 UNDERTAKER George L. Rust ADDRESS 1735 Hayford

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 21827

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21827

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2539. E Oliver ST. 8-16 (WARD)

2-FULL NAME William A. E. Wittgrefe

(a) RESIDENCE. No. 2539. E Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Wittgrefe

6 DATE OF BIRTH (month, day, and year): Jan 2 1863

7 AGE: Years 64 Months 3 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Wittgrefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles E. Wittgrefe Jr.

(Address) 2539. E Oliver St.

15 Filed 2-9-1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30. 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 10. 27. to Apl 30. 1927.

that I last saw h[illegible] alive on Apl 30. 1927.

and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

[illegible] William Myers M. D.

[illegible] 1801 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery DATE OF BURIAL: May 3. 1927

20 UNDERTAKER: Wm. H. Keefer & Son ADDRESS 801 W. Fayette

This is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

21828

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 21828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1170 Wash Blvd (ST.) 21-29 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena A. Janusch

(a) RESIDENCE No. 1170 Washington Blvd. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	51	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: John A. Janusch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Preiskon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss M. J. Janusch

(Address) 170 Washington Blvd.

15 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, that I attended deceased from Sept. 1925 to May 1 1927.

that I last saw h[illegible] alive on May 1 1927.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Kurz M. D.

5. 2. 1927 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 5/2/27

20 UNDERTAKER: Geo Leimbach & Sons

ADDRESS: 570 Lemmon St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21829

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21829

CERTIFICATE OF DEATH.

194-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Ceil Ave) 9-46 WARD

2-FULL NAME Mary M Francke

(a) RESIDENCE NO. 2228 Ceil Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius A Francke

6 DATE OF BIRTH (month, day, and year) May 23 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Hern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M Francke

(Address) 2228 Ceil Ave

15 Filed Apr 29, 1927 H. MARTIN JONES, M. D. Registrar ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1926, to Apr 29, 1927, that I last saw h alive on Apr 29, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Chronic nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Martin Jones, M. D.

May 27 1927 (Address) 1228 Ceil Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 6/3/27

20 UNDERTAKER Geo A Farley ADDRESS Fulton & Fayette

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21830

CERTIFICATE OF DEATH.

E 21830

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2827 Huntington Ave ST. 57 WARD 90)

2-FULL NAME Laura M. Johnson

(a) RESIDENCE NO. 2827 Huntington Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Johnson

6 DATE OF BIRTH (month, day, and year) May 20 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Pleasant Lytle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Rosier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Johnson
(Address) 2827 Huntington ave

15 Filed 1927 192 HAMILTON JONES, M. D. Registrar
Per ACR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular
Thrombosis
Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) John Hamilton, M. D.
(Coroner.)

5/2, 192 (Address) 2627 Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Balto Co — DATE OF BURIAL 5/4 1927

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 1259 North ave

Cor.—12-9-25—A Co.—200 Bks.

E 21831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153 E 21831

REGISTERED NO. 70-69

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert J. Hauf Sr.

(a) RESIDENCE NO. 2255 W. Balto. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cathryn M. Hauf

6 DATE OF BIRTH (month, day, and year): April 20, 1873

7 AGE: Years 54 | Months | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer: Balto. City

9 BIRTHPLACE (city or town): Balto. Md.

(State or country): May 1, 1927

10 NAME OF FATHER: Geo. L. Hauf

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Eva Schupp

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

PARENTS

14 Informant: Mrs. A. J. Hauf

(Address) 2255 W. Balto. St.

15 1927 C. HANSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Following extraction of tooth

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 1, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery | Date of Burial: May 3 1927

20 UNDERTAKER: F. A. Wauselka | ADDRESS: 705 S. Hanover

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 21832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 21832

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 329 Dolphin St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Stansberg

(a) RESIDENCE NO. 329 Dolphin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 3rd. 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Levi Stansberg

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Myer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Alice Wolf

(Address) 329 Dolphin St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1927, to May 2. 1927, that I last saw him alive on Apl 30 1927, and that death occurred, on the date stated above, at 7. A.M.

The CAUSE OF DEATH* was as follows: Chronic tubular Heart trouble - Complicate with Angina.

(daration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(daration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Jonas, M. D.

(Address) 1211 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship Cem.	5/4/ 1927
20 UNDERTAKER	ADDRESS
David Londheim	115-20 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 21833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 N. Spring St., 9-17 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward [illegible]

(a) Residence No. 1526 N. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary [illegible]

6-DATE OF BIRTH (month, day and year): 7/4/1845

7-AGE: 81 yrs. 10 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tanner

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Harry S. [illegible]

(Address) 1526 N. Spring Ave

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per RFH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 1 - 1927

17- I HEREBY CERTIFY, That I attended deceased from several years, 19.. to April 29, 1927

that I last saw him alive on April 29, 1927

and that death occurred, on the date stated above, at 4:55 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Arterio-sclerosis. Oedema limbs & Suppuration

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Arterio-sclerosis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. O. Carman M. D.

5-2, 1927 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dallas Cem. DATE OF BURIAL: 5/3, 1927

20-UNDERTAKER: Frederick A. Cole ADDRESS: 1411 Hollins St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Blks.

E 21834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21834

CERTIFICATE OF DEATH.

101-001

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhain Roberts

(a) RESIDENCE NO. 2631 Benna St St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-25-1924

7 AGE: Years 2 Months 4, Days 5 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Wm Roberts

11 BIRTHPLACE OF FATHER (city or town) Wales

(State or country)

12 MAIDEN NAME OF MOTHER Mattie Jones

13 BIRTHPLACE OF MOTHER (city or town) Pa —

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1927, to May 1, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 9:35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? Yes Date of Mar 25, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Thoracentesis.

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden Date of Burial: May 3 1927

20 UNDERTAKER: C Sumwalt Sons

ADDRESS: 3615 Chestnut Ave.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 21835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21835

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (B.B.) S. Ward

REGISTERED NO. 7433

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sabins

(a) RESIDENCE NO. 121 E. Cross st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sirgle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Sabins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Sabins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed C. HAMPTON JONES, M. D., Registrar

MAY 3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 1, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to May 1, 1927, that I last saw him alive on Mayl, 1927, and that death occurred, on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. E. Gattens, M. D.

5-2-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill, U.G.Co. Date of Burial May 5 1927

20 UNDERTAKER Chas. L. Storms. ADDRESS 1501 E. Fort Ave.

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21836

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21836

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3221 Fait Ave WARD) 26-1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filomena Ferrino

(a) RESIDENCE NO. 3221 Fait Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fmale	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Ferrino

6 DATE OF BIRTH (month, day, and year) Aug 10, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Calton Ferrino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mitrano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose Martinis

(Address) 3221 Fait Ave.

15 Filed 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to May 2, 1927, that I last saw h[illegible] alive on May 1, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Perrino, M. D.

May 2, 1927 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL May 2 1927

20 UNDERTAKER W. M. Cook ADDRESS 502 E Fait Ave

HOME is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21837

CERTIFICATE OF DEATH.

129

E 21837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 429 N. Carey St. 18-26 Ward)

2-FULL NAME Robert F Thompson

(a) RESIDENCE NO. 429 N. Carey St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Husband Anna A. Thompson

6 DATE OF BIRTH (month, day, and year): Mar. 15. 1867

7 AGE: Years 60 | Months 1 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Asst Yard Master

(b) General nature of industry, business, or establishment in which employed (or employer): R. R. Yard Master P. R. R.

(c) Name of employer: P. R. R.

9 BIRTHPLACE (city or town)

(State or country): Charles Co. Md.

PARENTS

10 NAME OF FATHER: Francis Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Charles Co. Md.

12 MAIDEN NAME OF MOTHER: Josephine Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Charles Co. Md.

14 Informant: Anna A. Thompson

(Address) 429 N. Carey St.

15 Filed ....., 19.. HARRISON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to May 2, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 2.45 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) 1 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary): Interstitial Nephritis Myocarditis

(duration) about 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical Test

What test confirm diagnosis?

(Signed) Harry G Cole M. D.

May 2. 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

Date of Burial: May 4 1927

20 UNDERTAKER: [illegible] Cook

ADDRESS: 502 E Lanvale

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21838

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1391 Woodyear ST. 15-23 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wheeler

(a) RESIDENCE (No.) 1391 Woodyear ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colred

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan - 1923

7 AGE — Years: 4 — Months: 3 — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Ada Connah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): John Wheeler 1391 woodyear

15 Filed ..... 1927 C. HARRISON JONES, M.D. ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Ap. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1927 to Ap-30-1927 that I last saw h[im] alive on April 29, 1927 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Medical

(Signed) Jas. H. Walters M. D.

19 (Address) 1035 N. Eutaw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 5-3 1927

20 UNDERTAKER: John H. Troadwell — ADDRESS: [illegible]

FOR is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ E 21839

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 413 N, Mount St (St.) 19-27 (Ward)

2-FULL NAME William Cephas Chase

(a) RESIDENCE NO. 413 N. Mount St. St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred All of life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Irene Jackson Chase

6 DATE OF BIRTH (month, day, and year): June 30, 1902

7 AGE: Years 24; Months 10; Days 0; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b). General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Mr. Banks

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Reason Chase

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Ellen Chase

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Calvert Co. Md.

14 Informant: Mrs. Elizabeth Chase (wife)

(Address): 413 N. Mount St.

15 Filed_____ 19____ 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927 to April 30 27

that I last saw him alive on April 30, 1927

and that death occurred, on the date stated above, at 7:12 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (acute)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death: At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial: 5-3 1927

20 UNDERTAKER: John H. Toadvine ADDRESS 1027 Druid Hill

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21840 90 E 21840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 N. Pacaste St. 17-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. Lee

(a) RESIDENCE NO. 605 N. Pacaste St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Lee

6 DATE OF BIRTH (month, day, and year): about 1868

7 AGE: Years 59; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B. & O. R. R.

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mrs. Robt. Lee

(Address) 605 N. Pacaste

15 Filed May 1927 C. HAMDEN JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy, M. D.

(Coroner)

May 1, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial 5-3 1927

20 UNDERTAKER: John H. Toadvine ADDRESS 1022 10th and Hill

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21841

CERTIFICATE OF DEATH.

E 21841

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 940 S. 3rd. St. St. 26-27 Ward)

2-FULL NAME Amalia Baier.

(a) RESIDENCE NO. 940 S. 3rd St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Baier.

6 DATE OF BIRTH (month, day, and year) July 26-1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George Becker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Werner.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Paul Baier Husband.

(Address) 940 S. 3rd St.

15 Filed 1927 Registrar

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30-1927

17 I HEREBY CERTIFY, That I attended deceased from April 27 1927 to April 30 1927, that I last saw h.. alive on April 30th 27, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cystic Ulcer of Cancer of Stomach (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Schmidt, M. D.

May 2, 1927 (Address) 1501 Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial May 5 1927

20 UNDERTAKER Lilly and Zeiler. ADDRESS 403 S. Wolfe St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21842

CERTIFICATE OF DEATH

89 E 21842

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 Collins Ave., St. 20-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia W Kaiserski

(a) RESIDENCE NO. 105 Collins Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John W. Kaiserski

6 DATE OF BIRTH (month, day, and year) April 7, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. J.

PARENTS

10 NAME OF FATHER Joseph Wilber,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Herman M. Kaiserski,

(Address) 4123 Potter St.

15 Filed C. HAMILTON JONES, M. D. Registrar

1927 Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1927, to May 1, 1927, that I last saw her alive on May 1, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Data of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. A Kuell, M. D.

5/2, 1927 (Address) Towson.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial May 5 1927

20 UNDERTAKER Harry Weyler — ADDRESS 1531 W. Fayette

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21843

31 E 21843

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 19-28

City of BALTIMORE: (No. 1821 Wilhelm St., St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace E. Crofoot.

(a) RESIDENCE NO. 1821 Wilhelm St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Crofoot

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Merson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Mary E. Crofoot

(Address) 1821 Wilhelm St.

15 Filed C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 19 26, to May 1, 19 27,

that I last saw h[illegible] alive on April 30, 19 27,

and that death occurred, on the data stated above, at 6 35 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. 5 mos. 27 ds.

CONTRIBUTORY (Secondary) Pulmonary Cardiac

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

5/2, 19 27 (Address) 1779 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial May 4 19 27

20 UNDERTAKER Harry A Hoffe — ADDRESS 1531 N. Fremont Ave

3 - 1927

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21844

E 21844

178

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of BALTIMORE: (No. Pronounced dead at Hopkins Hospital St. 5-8 Ward)

2-FULL NAME Addison J. Warfield

(a) RESIDENCE NO. 612 N. CentralAve St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Marcella Warfield

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....m'n.
	about 65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Joe Warfield

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Hager Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Jannie Warfield
(Address) 229 S. Caroline

15 Filed 1927 C. HARRISON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Smoke suffocation- accidental
Coal oil stove was overturned & set fire to floor
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Alcoholism
(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. W. Paton M. D.
(Coroner)

5/3/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md. Date of Burial May 3rd 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 21845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21845

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1033 Mt. St. Street W. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jones

(a) RESIDENCE NO. 1033 Mt. St. Street W. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Eugene Jones

6 DATE OF BIRTH (month, day, and year): 1905

7 AGE: Years 22 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Alex Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Mary J. Burnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Julia Tyler 1033 Mt. St. W.

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1927

17 I HEREBY CERTIFY That I attended deceased from Dec. 17th, 1926, to May 1927, that I last saw her alive on April 24, 1927, and that death occurred, on the date stated above, at 4:40 P. M.

The CAUSE OF DEATH* was as follows: Acute Tuberculosis

(Duration) 1 yrs. ✓ mos ds.

CONTRIBUTORY (Secondary): Pulmonary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1033 Mt. St. W.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 824 Mt. St. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elizabeth City N. C.

DATE OF BURIAL: May 3rd 1927

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pine

FROM is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+44 E 21846

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gray

(a) RESIDENCE NO. 1617 Westwood Ave St. Ward Va

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 days 12 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 42; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Riley Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER: Rachel [illegible]

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed —, 19 [illegible] Registrar

1927 C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1927

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to May 2, 1927, that I last saw h[illegible] alive on May 2, 1927, and that death occurred, on the date stated above, at 5-9- m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) — yrs. 12 mos. ds.

CONTRIBUTORY (Secondary): Infection in Bronchial Pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Taylor Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lancaster Va

Date of Burial: May 3 1927

20 UNDERTAKER: Howard Easton

ADDRESS 916 E Pratt

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21847

CERTIFICATE OF DEATH

E 21847

REGISTERED NO. 10-80

1-PLACE OF DEATH

City of BALTIMORE: (No.) Saint city Hospital St. 4-25 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Belis

(a) RESIDENCE NO. 608 W Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Joseph Belis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant City Hospt Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 29, 27

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 29, 1927

that I last saw him alive on April 29, 1927

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia left

Acute Endocarditis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. B. Purvis M. D.

, 19 (Address) Bellevue Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 5/3 1927

20 UNDERTAKER J J Fahey Sons — ADDRESS 718 Light St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21848

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Antonio

(a) RESIDENCE NO. 1016 E. Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Nicholas Antonio

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Marguerite Travis

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Records.

(Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible] 19[illegible] HAMILTON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1927

17

I HEREBY CERTIFY, That I attended deceased from September 29, 1926, to April 28, 1927, that I last saw him alive on April 28, 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? gen'l & laboratory

(Signed) R. Hooper Smith, M. D.

April 29 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial: 5/3 1927

20 UNDERTAKER: J. J. Daley Sons — ADDRESS: 1348 Light St

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21849

E 21849

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Booth St. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Edward Bryan

(a) RESIDENCE NO. 1023 Booth ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26. 1907

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica Md

12 MAIDEN NAME OF MOTHER Cecilia Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.A. Co Md

14 Informant (Address) Ruth Howard 1021 Booth

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 2, 1927, to April 30, 1927, that I last saw him alive on April 29, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 3 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Neville M. D.

5/2, 1927 (Address) 1191 W Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: May 3, 1927

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

Registered May 3 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21850 12 9 E 21850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1614 Cole (ST.) Hanover (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Clopein

(a) RESIDENCE NO. 1614 Cole ST., 20th WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Clopein

6 DATE OF BIRTH (month, day, and year): Feb 9th 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Georgen Speckermann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaretta Spank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John Clopein 1614 Cole St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per Rite

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30th 1927

17

I HEREBY CERTIFY, That I attended deceased (from) Jan 1, 1927, (to) April 30, 1927.

that I last saw alive on April 30, 1927.

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Neal to A City, M. D.

5/3, 1927 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 3rd 1927

20 UNDERTAKER: H. B. Wiepjut

ADDRESS: 155 W Balto St

HON is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21851 — CERTIFICATE OF DEATH. — E 21851

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO.

CITY OF BALTIMORE, (No.) ... St. 11-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Beaver

(a) RESIDENCE NO. Catonsville Md St., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of / WIFE of: Minnie R. Beaver

6 DATE OF BIRTH (month, day, and year): Feb 9, 1882

7 AGE — Years: 45 — Months: 2 — Days: 21 — If LESS than 1 day, hrs. or min.: 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa.

PARENTS

10 NAME OF FATHER: Geo. R Beaver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa.

12 MAIDEN NAME OF MOTHER: Emma Williford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Pa

14 Informant (Address): Deceased Catonsville Md

15 Filed: May 6 1927 — Registrar: C. HARRISON JONES, M. D. — Per: M.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to May 1st, 1927, that I last saw h/M alive on May 1st, 1927, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary): Pesitonitis

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 4-29-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

, 19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: May 4, 1927

20 UNDERTAKER: F. B. Hepburt, 1850 W. Baltimore — ADDRESS

FROM is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21852

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21852

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 Fleet St. St. 2-4 Ward)

2-FULL NAME John Kataiczak (sometimes known as Kay.

(a) RESIDENCE NO. 1615 Fleet St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Dec 2 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
54 55		4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mary Kataiczak (Ray)

(Address) 1615 Fleet St

15 May 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to May 1, 1927,

that I last saw h__ alive on May 1st, 1927,

and that death occurred, on the date stated above, at 11-5 A.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edith Riley, M. D.

May 7, 1927 (Address) 1008 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Date of Burial 5/11 1927

20 UNDERTAKER F. W. Ozarowski ADDRESS 1930 Eastern Ave

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

21853

HEALTH DEPARTMENT—CITY OF BALTIMORE

21853 4qE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Oxford & Norwood Ave St. Howard Pk (Ward) 28-64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred W. Muthert

(a) RESIDENCE NO. Oxford & Norwood Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ray Muthert

6 DATE OF BIRTH (month, day, and year) 2/15/1869

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
58	2	16 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Safety Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Am. Mutual Ins. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Muthert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Muthert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Ray Muthert

(Address) Oxford & Norwood Avenues

15 Filed ... 1927 C. MARSH JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to May 2, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spine

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Paraplegia

(duration) ... yrs. 1 mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lumpkin, M. D.

5/4 1927 (Address) 826 N Curtis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — Date of Burial: 5/4 1927

20 UNDERTAKER: Albert L Hilt Jr — ADDRESS: 1606 N. Chester st

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Amtler

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 E 21854

CERTIFICATE OF DEATH.

× 84 E 21854

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT. St., 7-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Amtler

(a) RESIDENCE NO. Hummelstown - Lancaster Pa Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER A - Lin Amtler

11 BIRTHPLACE OF FATHER (city or town) Pa -

(State or country)

12 MAIDEN NAME OF MOTHER Ella Herr

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPIT.

15 Filed MAY 4 - 1927 12 C. HAMPTON JONES M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17

I HEREBY CERTIFY, That I attended deceased from May 2 1927, to May 3, 1927, that I last saw him alive on May 3, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) .....yrs. 1 mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 5/3/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + operation

(Signed) George E. Finney, M. D.

5/3/27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Halfwood Pa — Date of Burial: 5/4/27

20 UNDERTAKER: Joseph Abrens — ADDRESS: 221 Bway

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

02433 E 21855 — E 21855

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI St., 79 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Fleming

(a) RESIDENCE NO. Colen - Pa - St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 0 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: David Fleming

6 DATE OF BIRTH (month, day, and year): Sept 22, 1869

7 AGE: Years 57; Months 7; Days 11; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Pa -

(State or country)

PARENTS

10 NAME OF FATHER: James McGee

11 BIRTHPLACE OF FATHER (city or town): Pa -

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz Boyce

13 BIRTHPLACE OF MOTHER (city or town): Pa -

(State or country)

14 Informant: Friends

(Addr JOHNS HOPKINS HOSPIT

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25 1927, to May 3, 1927, that I last saw her alive on May 3, 1927, and that death occurred, on the date stated above, at 4.15 p.m.

The CAUSE OF DEATH* was as follows:

Cholangitis - acute

Cholecystitis - chronic

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Pyelophlebitis + peritonitis R side

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Penna

Did an operation precede death? Yes Date of Dec 5-1926

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Warfield Theobald, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnstown, Penna — Date of Burial: May 4 1927

UNDERTAKER: John O. Mitchell — ADDRESS: 1900 Eutaw Pl

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 21856

(Heavene)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21856

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Hawes

(a) RESIDENCE NO. 1819 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 63 Months Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER Calvin Irving

11 BIRTHPLACE OF FATHER (City or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Bryan

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Hospital Records

(Address)

15 Filed ....., 19 .....

Per ..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1927, to May 1st, 1927, that I last saw h[illegible] alive on May 1st 1927, and that death occurred, on the date stated above, at 5 15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Edwin M. Robertson, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Whitestone Pa

Date of Burial: May 4 1927

20 UNDERTAKER: George L. Schmit

ADDRESS: 2101 Eutaw Pl.

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

20 E 36 21857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 84 E 21857

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI. St., 24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arstal Reese

(a) RESIDENCE NO. Jackson Ohio St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER Everett Reese

11 BIRTHPLACE OF FATHER (city or town) Ohio

(State or country)

12 MAIDEN NAME OF MOTHER Nancy Perkins

13 BIRTHPLACE OF MOTHER (city or town) Ohio

(State or country)

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPI. BALTIMORE, MD.

15 Filed MAY 4 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 3, 1927, that I last saw him alive on May 3, 1927, and that death occurred, on the date stated above, at 11 9 — m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 4 mos. 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 5/3/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George G. Fisher, M. D.

5/3/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamden Ohio — Date of Burial 5/7/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21858

CERTIFICATE OF DEATH.

151 X E 21858

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore Hospt. 04-33 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Pier

(a) RESIDENCE NO. Summer St. N. J. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 13 - 1888

7 AGE: Years 38 | Months 8 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Jersey.

PARENTS

10 NAME OF FATHER Irwin Rice

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. J.

12 MAIDEN NAME OF MOTHER Eugenia Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. J.

14 Informant: South Balto Genl Hosp

(Address) Long Lt. N. J.

15 Filed ..... 19 .....

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-3-27 19

17

I HEREBY CERTIFY, That I attended deceased from 4-16-, 19 27, to 5-3, 19 27,

that I last saw alive on 5-3, 19 27,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Infected leg & pneumonia

Empyema leg (Rt)

(duration) yrs. mos. 17 dys.

CONTRIBUTORY (Secondary) Infected toe

(duration) yrs. mos. 2 dys.

18 Where was disease contracted

If not at place of death? No

Did an operation precede death? No Date of 4-18-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Harris M. D.

, 19 (Address) South Balto Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hammonton N J — Date of Burial May 4 1927

20 UNDERTAKER: Maryla Gawthrop — ADDRESS 2009 Roper Av

Very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21859 (17662)

CERTIFICATE OF DEATH.

161-6001

E 21859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2408 E Federal St. 8-16 Ward)

2-FULL NAME Gustav Adolph James

(a) RESIDENCE NO. 2408 E Federal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 hrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	S—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2-1927

7 AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Ellwood F. James

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Emma Lachmit

13 BIRTHPLACE OF MOTHER (city or town) Kansas (State or country)

14 Informant Hilda Eicholtz (Address) 2408 E Federal St.

15 Filed May 4 1927, 19 C. HARVEY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17

I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw h— alive on May 2, 1927,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James L Kerkenbush M.D.

5/3, 1927 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Cemetery Ellicott City	May 4 1927
20 UNDERTAKER	ADDRESS
Jas. W. Starr	Ellicott City

FROM IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks. Mary Elizabeth Thorne

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 21860

CERTIFICATE OF DEATH.

E 21860 REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. University Hosp. ST., 15-62 WARD)

2-FULL NAME Thorne —, Mary Elizabeth

(a) RESIDENCE NO. 3000 Hatherol ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Thorne

6 DATE OF BIRTH (month, day, and year) Feb 23, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles F. Hinder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant John Thorne (Address) 3000 Hatherol

15 Filed 7 - 1927, 19 C. HARRY JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to May 2, 1927, that I last saw h[illegible] alive on May 2, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

~~Cerebral Hemorrhage~~

Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-29-27

Was there an autopsy? no

What test confirmed diagnosis? Clinically & Operation

(Signed) R. D. Lindgren, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery DATE OF BURIAL May 6 19 27

20 UNDERTAKER Harry H. Witzke ADDRESS 153 W. Lombard

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

St. Joseph's 3 3rd 26, Frederick

E 21861

CERTIFICATE OF DEATH

86

E 21861

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5 N Hilton St. St. 20-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mona G. Griffin.

(a) RESIDENCE NO. 5 N. Hilton St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1885

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
42	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Maurice Griffin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland,

12 MAIDEN NAME OF MOTHER Julia Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland,

14 Informant Agnes Griffin

(Address) 5 N Hilton St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5/1/27

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to 5/1, 1927

that I last saw h[illegible] alive on 5/1, 1927

and that death occurred, on the date stated above, at 7 30A m.

The CAUSE OF DEATH* was as follows:

Vegetative Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolus

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finsberg?

(Signed) Samuel P. Gl[illegible] M. D.

, 19 (Address) 33 26 Fr[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial May 5 1927

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21862

CERTIFICATE OF DEATH.

74-001

E 21862

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 923 Clifford St. (Ward) 20-27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward O'Brien

(a) RESIDENCE NO. 406 N. Brice St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 18 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	79	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Livery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

024

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Alverta M. O'Brien

(Address) 919 Washington Blvd

15 Filed MAY 4 1927 Per H. P. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.

(Coroner)

May 3rd 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — Date of Burial May 4 1927

20 UNDERTAKER Harry A. Arnaud — ADDRESS 4209 Ridgewood Ave

very important. See instructions on back of certificate. — STATEMENT OF OCCUPATION IS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21863

CERTIFICATE OF DEATH.

125 E 21863

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Weinraub

(a) RESIDENCE NO. 207 N Patterson Pk St. Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 49 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Israel Roffle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Goldie Smallon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sam. Roffle

(Address) 207 N. Patterson Pk Ave

15 Filed ....., 19..... Registrar C. HARRY JONES, M. D.

Y 4 - 1927 Per R M C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 3 - 1927.

17

I HEREBY CERTIFY, That I attended deceased from 5-2, 1927, to 5-3, 1927,

that I last saw h.. alive on 5-3, 1927,

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

Cardiac failure (duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Sign

(Signed) H Edmund Sign, M. D.

5/3 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Southern Date of Burial 5/4 1927

20 UNDERTAKER: Solomon & Bro ADDRESS 1127 E Balto St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21864

CERTIFICATE OF DEATH.

101-001

E 21864

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ward

(a) RESIDENCE NO. 141 W. Hamburg st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Abraham Ward

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Hattie ? 5-1-27

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 4-1927, 19 C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1927 19

17 I HEREBY CERTIFY, that I attended deceased from April 28 19 27 to April 30 19 27, that I last saw him alive on April 30 19 27, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Lattem, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Date of Burial 4. 4 1927

20 UNDERTAKER R. L. Parham ADDRESS 1216 E. Shaw St.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21865

CERTIFICATE OF DEATH.

E 21865

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 S. Warner ST. 21-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Massey

(a) RESIDENCE NO. 704 S. Warner ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-1-27

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Massey

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margie Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address)

15 Filed 4-1927, 19 ... Registrar

C. MAYO JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-1, 1927, to 5-1, 1927.

that I last saw her alive on 5-1, 1927

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Maternal Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Era F. Dodge, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery of Md.

DATE OF BURIAL ... 19

20 UNDERTAKER ...

ADDRESS ...

Read very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21866

CERTIFICATE OF DEATH.

101-001

E 21866

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Douglas

(a) RESIDENCE NO. 1106 Duke Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Douglas

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Douglas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Trezinia —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed MAY 4 - 1927 C. H. [illegible] JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27 1927, to May 1, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) R. Hoopa Smith, M. D.

May 3 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — Date of Burial: may 4 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1681 orleans st

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21867

CERTIFICATE OF DEATH.

90 ✓ E 21867

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Acton

(a) RESIDENCE NO. 2550 Fairmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Acton

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Washington

(State or country) D.C.

PARENTS

10 NAME OF FATHER Elijah Acton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Camilla —

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

15 Filed 19

MAY 4 - 1927

Per HAYDN JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1927, to May 1, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 4:35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Leavitt, M. D.

May 3 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial May 5 1927

UNDERTAKER: Wellman Bros

ADDRESS: 2026 Eutaw

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) ST., 25-77 WARD

2-FULL NAME Anna Butner

(a) RESIDENCE NO. 801 Pennington Ave ST., Curtis Bay WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred cmk mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Butner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe

PARENTS

10 NAME OF FATHER John Stephen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. G. L. Clarke

(Address) 901 Pennington ave

15 Filed MAY 4 1927 C. RAY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to May 2, 1927, that I last saw h[illegible] alive on May 2, 1927, and that death occurred, on the date stated above, at 9 30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Catonsville DATE OF BURIAL May 5 1927

20 UNDERTAKER Margaret E. Flynn ADDRESS 1422 Light

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21869

CERTIFICATE OF DEATH

90 E 21869

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2702 Maryland Ave. St., 17-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bowly Gill Kinear

(a) RESIDENCE NO. 2702 Maryland Ave St. 17 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 1 mos. 18 ds. How long in U. S. if of foreign birth? 89 yrs. 1 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James C. Kinear

6 DATE OF BIRTH (month, day, and year) March-13-1838

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	89	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George M. Gill

11 BIRTHPLACE OF FATHER (City or town) Balto. Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann McKim Bowly

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country) Maryland.

14 Informant Miss. Mary E. Kinear (daughter)

(Address) 2702 Maryland Avenue

15 Filed MAY 4 - 1927 19 C. HAYWARD JONES, M. D. Registrar

Per R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May - 1 - 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to May 1, 1927, that I last saw h[er] alive on May 1, 1927, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert A. Mitchell, M. D.

May 5, 1927 (Address) 1117 Mary Land Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — Date of Burial May-4-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. [illegible], Successor) — ADDRESS 108 W. NORTH AVE

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—6-9-19—H. F. Co.—1000 Bks.

E 21870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21870

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 4902 Park Heights Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Rusk

(a) RESIDENCE. NO. 1624 Bolton ST.... WARD. Resident

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 78 yrs 0 mos. 11 ds

PERSONAL AND STATISTICAL PARTICULARS

3 Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) April 22/1849

7 AGE | Years 78 | Months 0 | Days 11 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Harford Co Maryland

PARENTS

10 NAME OF FATHER Jacob Rusk

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Penna.

12 MAIDEN NAME OF MOTHER Eliza Tracey

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Penna

14 Informant Miss Margaret Millard (Friend)

(Address) 2769 W North Ave

15 Filed ... 1927 ... 19 C. HAMPSON JONES, M. D. Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1926 to May 3 1927.

that I last saw her alive on May 2 1927.

and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Arterial Hypertension

(duration) 2 yrs — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) — yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) 318 North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	May 5 1927
20 UNDERTAKER Stewart Monn & Co	ADDRESS Balto. Md

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21871

CERTIFICATE OF DEATH

37

E 21871

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals St. (or B. C.) 90-169 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Landwear

(a) RESIDENCE NO. 2549 Frederick ave. St. 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Howard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

Filed MAY 4 1927 C. HAMILTON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 19, 19 27 to May 3, 19 27

that I last saw her alive on May 3, 19 27

and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous pyelitis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatteus M. D.

5-3-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial May 6 19 27

20 UNDERTAKER F. A. Wippert ADDRESS 1850 N. Bucknell

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21872

CERTIFICATE OF DEATH.

E 21872

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Cleveland & Bayard St. Ward)

2-FULL NAME Creighton G. Barnes

(a) RESIDENCE NO. Fort Meyers, Fla St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) May 10th 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Cora Lamb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant David W. Barnes

(Address) Fort Meyers, Fla

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest

find that said deceased came to death

(Autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Found dead

CONTRIBUTORY (Secondary)

duration yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

May 3rd, 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial May 4th 19 27

20 UNDERTAKER H. B. Philpott ADDRESS 150 N. Paca St

MAY 4 - 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21873

CERTIFICATE OF DEATH.

168 E 21873

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1321 S. Carey Street 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Gotleib Werner

(a) RESIDENCE NO. 1321 S. Carey Street. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Werner

6 DATE OF BIRTH (month, day, and year) May 27, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General natnre of indnstry, business, or establishment in which employed (or employer) --

(c) Name of employer Baltimore & Ohio R. R.

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Minnie Werner

(Address) 1321 S. Carey St.

15 Filed ..... 19 ..... Registrar

MAY 4 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 2nd. 1927 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation.

(coroner)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide.

(Signed) Hor B. Horton M. D.

(Coroner)

May 3rd 1927 (Address) 1 Cedar St. Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See rules for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) --

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetry Date of Burial 5/4/27 19

20 UNDERTAKER Jos Joerdens & Son ADDRESS 2078 Pen

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21874

CERTIFICATE OF DEATH

118-001

E 21874

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE, (No. 1507 N Durham St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Engels

(a) RESIDENCE NO. 1507 N Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Engelbert Engels

6 DATE OF BIRTH (month, day, and year): July 25 1848

7 AGE: Years 79 Months 2 Days 7

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: John Engels

(Address): 1507 N Durham

Filed MAY 4 1927 19 ... C. ELMO JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 2. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22 1927, to May 2 1927, that I last saw h... alive on May 2 1927 and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) hrs. mos. ds.

CONTRIBUTORY Edema due to Intest. Obstruction (over)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What ... confirmed diagnosis? Physician Extract

... Louis H. H. M. Eyer M. D.

5/3, 19 27 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: May 7 1927

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Orleans

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21875

CERTIFICATE OF DEATH.

REGISTERED NO. E 21875

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Jones

(a) RESIDENCE NO. 1312 N Franklin St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 10 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas A. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Malone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas Malone
(Address) 1312 Franklin St

15 Filed MAY 4 - 1927 By C. HARRISON ROBERTS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to May 1, 1927,
that I last saw h[illegible] alive on May 1, 1927,
and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured Urethra & Extravasation of urine

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 23-1927

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 4 1927

20 UNDERTAKER Samuel Hemsley ADDRESS 1 Eddie

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21876

CERTIFICATE OF DEATH.

74-001

E 21876

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1940 N. Lexington St. (Ward) 20-27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence D. Jackson

(a) RESIDENCE NO. 1940 N. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 18 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur L. Jackson Sr

6 DATE OF BIRTH (month, day, and year) Dec 14 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	53	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Geo. Dentry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Georgiana McCoy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Arthur L. Jackson Sr

(Address) 1940 N. Lexington St.

15 Filed 1927 C. PAUL JONES, M. D.

Per R.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 6 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. D. Morton M. D.

(Coroner)

May 3rd, 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Date of Burial May 5 1927

20 UNDERTAKER Geo. G. Little ADDRESS 720 Edmondson

Very important. See instructions on back of certificate.

4

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21877 E 21877

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH 1629 N. Bond St 817 Registered No.

City of BALTIMORE; (No. 1629 N. Bond St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sedonia A. Brauer

(a) Residence No. 1629 North Bond St., Ward 8
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of The late Peter Brauer

6-DATE OF BIRTH (month, day and year) July 17 1846

7-AGE. 80 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Meisner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Agnes Monshaw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-
(Informant) George L. Brauer (Son)
(Address) 1649 N. Bond St

15-
MAY 4 - 1927 (Date received) C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1927

17- I HEREBY CERTIFY, That I attended deceased from April 2 1927 to May 3 1927 that I last saw her alive on May 3 1927 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical tests

(Signed) A. A. Kaadonagh M. D.
, 19 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore County — DATE OF BURIAL. May 5th 1927

20-UNDERTAKER. George Schilling & Sons — ADDRESS 1126 E. Monument St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21878

CERTIFICATE OF DEATH.

E 21878

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia E. Meyer

(a) RESIDENCE NO. 2814 Parkwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Harry H. Meyer

6 DATE OF BIRTH (month, day, and year): March 12 1878

7 AGE: Years 49 Months 1 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Schlikner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Harry H. Meyer

(Address) 2814 Parkwood Ave

15 Filed MAY 4 - 1927 H. HARRISON JONES, M. D. Registrar

Per R.L.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 2. 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D. (Coroner)

May 4 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lewis Ridge Cemetery Date of Burial: May 5. 1927

20 UNDERTAKER: Josiah Lyffer ADDRESS: 1600 N. Mon

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Walker

E 21879 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21879

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 748 W Franklin ST. 17-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Walker

(a) RESIDENCE NO. 748 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Walker

6 DATE OF BIRTH (month, day, and year) ? 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Walker

(Address) 748 Franklin st

15 Filed 4-1927 By C. Hall Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927 to May 1, 1927 that I last saw him alive on May 1, 1927 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Cloudy, M. D.

, 19 (Address) 729 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL 5/4/27

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

Spec.-7-17-26—M.Co.—200Bks. E 21880

HEALTH DEPARTMENT—CITY OF BALTIMORE E 21880

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH — REGISTERED NO. _____

City of BALTIMORE: (No. 1406 Bolton Street St. 14-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Louisa Hilt

(a) RESIDENCE NO. 1406 Bolton Street St. _____ Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ? mos. ? ds. How long in U. S. if of foreign birth 82 yrs. 6 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George C. Hilt

6 DATE OF BIRTH (month, day, and year) October-21-1844

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	82	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Hanover

(State or country) Penna.

PARENTS

10 NAME OF FATHER Jacob Grove

11 BIRTHPLACE OF FATHER (City or town) Hanover

(State or country) Penna.

12 MAIDEN NAME OF MOTHER Louisa Shriver

13 BIRTHPLACE OF MOTHER (city or town) Littlestown

(State or country) Penna.

14 Informant Miss. Grace E. Hilt (daughter)

(Address) 1406 Bolton Street.

15 Filed MAY 4 1927 19 C. HARRISON JONES, M. D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1927, to May 4th, 1927, that I last saw h[illegible] alive on May 3rd, 1927, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

Senil (duration) ____ yrs. ____ mos. — da.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. Harned M. D.

May 4th 1927 (Address) 1727 Linden Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover, Penna. — Date of Burial May-6-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH AVE.

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21881
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-002

E 21881
REGISTERED NO.

CITY OF BALTIMORE: (No. 1237 Harford Ave. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Dougherty

(a) RESIDENCE No. 1237 Harford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles J. Dougherty

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Roney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) On Steamer
(State or country) En route to U.S.A. from Ireland

14 Informant Mrs. Carrie Morrow
(Address) 1237 Harford Ave.

15 Filed 4 1927 Harry Jones, M.D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3d 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to May 3, 1927,
that I last saw h[illegible] alive on May 2, 1927,
and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. F. Hayden, M.D.

5/4. 1927 (Address) 1216 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 5, 1927 19
20 UNDERTAKER	ADDRESS
Henry W. Means & Son	505 N. Calvert St.

Cor. 1[illegible]—A Co.—200 Bks.

21882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

E 21882

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. Ward)

2-FULL NAME Wm. H. Gerberg

(a) RESIDENCE NO. 2908 Belmont Ave Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced BUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1 1924

7 AGE: Years 2 Months 6 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Philip Gerberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Gimmitsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Philip Gerberg

(Address) 2908 Belmont Ave

15 Filed MAY 4 - 1927 HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.

(Coroner)

1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem Date of Burial 5/4 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21883

CERTIFICATE OF DEATH.

41

REGISTERED NO. E 21883

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1234 Carroll St. 21-29 Ward)

2-FULL NAME Ida A. Simon

(a) RESIDENCE NO. 1234 Carroll St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Simon

6 DATE OF BIRTH (month, day, and year) Jan 21, 1864

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
63	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wolstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Henry Simon

(Address) 1234 Carroll St.

15 Filed [illegible] 19[illegible] [illegible] Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17

I HEREBY CERTIFY, That I attended deceased from April 10 1927, to May 3, 1927, that I last saw h[illegible] alive on May 2, 1927, and that death occurred, on the date stated above, at 12.50 m.

The CAUSE OF DEATH* was as follows:

Infection of foot

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Gustav Dill, M. D.

5/4, 1927 (Address) 1504 E. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial May 5 1927

20 UNDERTAKER Chas. W. Dill. ADDRESS 3109 Fredk Ave.

MAY 4 1927 C. HAMILTON JONES M. [illegible]

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

701989

E 21884

+ 50 E 21884

E 21884

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI St., 7-9 Ward)

2-FULL NAME Benjamin Winn

(a) RESIDENCE NO. Schoolfield - Va St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. B. Winn

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 43 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER James Winn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Nannie Bell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPI

15 Filed 4 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1927, to May 4, 1927, that I last saw h. alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Spinal Cord Tuma, angioma

(duration) ___ yrs. 5 mos. ___ ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) ___ yrs. ___ mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/20/27.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and autopsy

(Signed) George E. Finney, M. D.

5/4/27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Danville Va — Date of Burial: 5/4/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 21885

CERTIFICATE OF DEATH.

E 21885

1 PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 9-18 WARD)

2-FULL NAME Andrew C. Hogan

(a) RESIDENCE NO. 1331 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Minnie W. Hogan.

6 DATE OF BIRTH (month, day, and year) Aug. 3-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	42	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) U.P.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Ilmer F. Hogan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary. McArdel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Andrew. C. Hogan.

(Address) 1331 Valley St.

15 Filed MAY 4 1927 HARRISON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26. 1927. to May 2 1927.

that I last saw h in alive on May 2. 1927.

and that death occurred, on the date stated above, at 11:00p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumnia -

(duration) yrs. mos 3 wks. dys.

CONTRIBUTORY (Secondary) Cardiac dilatation.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ——

Was there an autopsy? No.

What test confirmed diagnosis? Clinical—

(Signed) H.R. McCardell M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemty.	May 5 1927

20 UNDERTAKER ADDRESS

Geo. L. Pratt 1725 Harford ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21886

CERTIFICATE OF DEATH

E 21886 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1415 E Pratt St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hyman

(a) RESIDENCE NO. 1415 E Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S. if of foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Louis Lipschitz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Celia —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Lena Miller

(Address) 1415 E Pratt St

Filed MAY 4 - 1927 HARRY JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1926, to May 3, 1927.

that I last saw he alive on May 3 1927.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Lab.

(Signed) D. A. Michelson, M. D.

May 4. 1927 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

Date of Burial 5/4 1927

20 UNDERTAKER [illegible]

ADDRESS 1127 E Baltimore St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21887

CERTIFICATE OF DEATH

E 21887

1-PLACE OF DEATH South Balto Gen. Hosp. REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thornton Enoch Roberts

(a) RESIDENCE NO. 1540 William St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hazel Roberts

6 DATE OF BIRTH (month, day, and year): Dec 1891

7 AGE: Years 35 | Months 5 4 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Turkish Bath

(b) General nature of Industry, business, or establishment in which employed (or employer): attendant

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER: Geo W. Roberts

11 BIRTHPLACE OF FATHER (city or town): Geo W. Roberts Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Ard

13 BIRTHPLACE OF MOTHER (city or town): Balto Md

(State or country)

14 Informant: Geo W Roberts (Father)

(Address) 1540 William St

Filed MAY 4 1927 C. HAMPTON JONES, M. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1927

17

I HEREBY CERTIFY, That I attended deceased from 4-30, 1927, to 5-2, 1927,

that I last saw him alive on 5-2, 1927,

and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

due to Fracture necessary to the Registration

Contributory (Secondary) Fract. Skull

(duration) 4 yrs. mos. 2 ds.

Contributory (Secondary) drowned in shallow pool

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Micro. Spinal Fluid

(Signed) C. Hampton Jones M. D.

, 19 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem Date of Burial May 5, 1927

20 UNDERTAKER: A. Haas and Sons ADDRESS 38 E Fat Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 21888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U. S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md ST., 76-29 WARD)

2-FULL NAME James J. Mulligan.

(a) RESIDENCE NO. 3504 E. Balt. St City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 1860 August 7 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9 11	8 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Tug Boat Elsie. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un Known

12 MAIDEN NAME OF MOTHER Anne Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Self.

Filed MAY 4 - 1927 19 C. HAMPTON JONES, M. D. Registrar

Per RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17

I HEREBY CERTIFY, That I attended deceased from May 11, 1926, to May 2, 1927, that I last saw him alive on May 2, 1927, and that death occurred, on the date stated above, at 11-35 m.

The CAUSE OF DEATH* was as follows:

Carcinoma, bladder

from)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings and laboratory tests

(Signed) J. C. Graves, M. D.

, 19 (Address) U S Marine Hospital Balt. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 5/4 1927

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21889 E 21889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) 3343 (St.) Chestnut Ave (Ward) 13-5

REGISTERED No. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Barbara Dolan

(a) RESIDENCE NO. 3343 (Usual place of abode) Chestnut Ave WARD .....

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J Dolan

6 DATE OF BIRTH (month, day, and year) June 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Joseph's Balto co Md

PARENTS

10 NAME OF FATHER Frank Hilleke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anthony Gallagher (Address) 3908 Fairmont

Filed May 5, 1927 C. HARRY JONES, M. D. Per RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26 1927 to May 2, 1927 that I last saw h[illegible] alive on May 2 1927 and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Motta M. D.

5/2, 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmorton Harford Co Md DATE OF BURIAL May 5 1927

UNDERTAKER J Walter Davis ADDRESS 3307 Paine St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21890 E 21890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital 77 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3306 Tudor Ave ST. 13-5 WARD)

2-FULL NAME Mrs Grace L Miller

(a) RESIDENCE NO. 3306 Cedar Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Albert Miller

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Albert N. Miller 3306 Tudor Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RKN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to May 4, 1927, that I last saw her alive on May 3, 1927 and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows: Dementia Praecox

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B to M N

(Signed) [illegible] M. D.

5/4, 1927 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Market Md. DATE OF BURIAL: May 7 1927

20 UNDERTAKER: J. Walter Davis ADDRESS: 336 Rising

FAILURE IN VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—1-12-23—M&T—500 Bks.

E 21891 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21891

CERTIFICATE OF DEATH.

60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST. 24 WARD 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jamie Sarah Bexton

(a) RESIDENCE NO. 603 E. Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of J. Nelson Bexton

6 DATE OF BIRTH (month, day, and year) July 12-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Ingle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Ingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Nelson Bexton (Address) 603 E. Randall St

15 Filed 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 3. 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 27. 1926, to 5.3.27, 19

that I last saw h[illegible] alive on 5.3.27, 19

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

Sudden

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exophalmic Goitre

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5.3.27

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Philip R. Fowler, M. D.

5.3.27, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem. DATE OF BURIAL May 6 1927.

20 UNDERTAKER J. Walter Davis ADDRESS 3307 Paine St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21892

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1114 N. Eutaw St. 11/24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta W. Heim

(a) Residence No. 1114 N. Eutaw St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 21 1877

7-AGE, 50 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House 010

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Fredrick Heim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Adelheit Bayler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Mr. John Heim

(Address) 1114 N. Eutaw st

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2/27

17- I HEREBY CERTIFY, That I attended deceased from April 25 19 27 to May 2 19 27

that I last saw h[illegible] alive on May 1st 19 27

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) + Dr. Herrman M. D.

May 3 27 (Address) 7913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn County	May 4 1927
20-UNDERTAKER.	ADDRESS
George L. Ruth	1735 Harford Ave

Spec.—1-12-23—M&T—500 lbs.

E 21893

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 27553

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 12 Englewood Road St. Paul Ward

2-FULL NAME Emily J Freeman

(a) RESIDENCE No. 12 Englewood Road St R.P. WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND OF~~ (or) WIFE of: late Dr E J Freeman

6 DATE OF BIRTH (month, day, and year): May 26 1854

7 AGE: Years 72 Months 11 Days 23 If LESS than 1 day, hrs or min 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Shimmsville Pa.

PARENTS

10 NAME OF FATHER: John Knecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Danew Twp. Northampton Co. Penna.

12 MAIDEN NAME OF MOTHER: Elizabeth Riegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Riegelsville Pa.

14 Informant: R. D. Mueller (Address): 12 Englewood Rd.

15 Filed: 1927 .19 Registrar: C. BAMPTON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-6 .1926, to 5-3 .1927, that I last saw h~~er~~ alive on 5-3 .1927 and that death occurred, on the date stated above, at 12 M-N

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
Diabetes Mellitus
Myocarditis

(duration) 1-2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes- What test confirmed diagnosis? Clinical findings

(Signed) W A Wood, M. D.

.19 (Address) 402 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethlehem Pa Freemansburg

DATE OF BURIAL: May 5 1927

20 UNDERTAKER: Henry Heukins & Son Co

ADDRESS: Orchard & Pa Ave Catty

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21894

CERTIFICATE OF DEATH

44 E 21894

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 306 S. Stricker St., 14-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Warfield

(a) RESIDENCE NO. 306 S. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan O Warfield

6 DATE OF BIRTH (month, day, and year): Feb 5th 1846

7 AGE: Years 81 Months 2 Days 22

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Carroll Co

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Day

11 BIRTHPLACE OF FATHER (City or town): Carroll Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Amelia McKnew

13 BIRTHPLACE OF MOTHER (city or town): Howard Co

(State or country): Md

14 Informant: Leon Brooks

(Address): 17 S Calhoun St

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/2, 19 26, to May 2, 19 27

that I last saw her alive on May 2, 19 27

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary): Cirrhosis of Liver

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Kraemer, M. D.

5-3-, 1927 (Address) 706 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgan Chapel C. Co. Carroll Co Md

Date of Burial: May 5 1927

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun & Hollins Sts

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21895 (2123)

CERTIFICATE OF DEATH.

109-002

E 21895

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JNS HOPKINS HOSP St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Johnson

(a) RESIDENCE NO. 1644 Millinan St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-9-1923

7 AGE: Years 4 yrs; Months 3; Days 18; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ind

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ind

12 MAIDEN NAME OF MOTHER Lenina Cornnage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ind

14 Informant Records

(Address) JNS HOPKINS HOSP... JOHNS HOPKINS HOSPITAL

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 27/27

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1927, to April 27, 1927, that I last saw h.. alive on Apr. 14, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis abscess

Acute cervical adenitis

(duration) ...yrs. One mos. ...ds.

CONTRIBUTORY (Secondary) Empyema Septicemia

(duration) ...yrs. ...mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-14-27

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) I. Rio Levan Trumbo, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER: Commissioner Health ADDRESS: MAY 1 - 1927

Per. Wm. S. Tyndall

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21896

CERTIFICATE OF DEATH.

E 21896

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT St., 7-9 Ward)

2-FULL NAME Theresa Pecoraro

(a) RESIDENCE NO. 165 Bay 37 Brooklyn N. Y. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-17-26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	1	17	

14 mos

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) New York

PARENTS

10 NAME OF FATHER Charles Pecoraro

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Bash

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) N. Y.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed.....19 C. HARRISON JONES, M. D.

Registrar

5 - 1927 Per RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

May 4

17

I HEREBY CERTIFY, That I attended deceased from May 2 1927, to May 4 1927, that I last saw h.. alive on May 4 1927, and that death occurred, on the date stated above, at 4.20 p m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Brain

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Post-operative shock

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy and Operation

(Signed) George G. Finney, M. D.

5/4/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N.Y. Date of Burial 5/4/27

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21897

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 111-08

CITY OF BALTIMORE: (No. ..... ST., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Briscoe

(a) RESIDENCE NO. Mutual, Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Duke Bacon

6 DATE OF BIRTH (month, day, and year) Dec. 12 55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Jas P. Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Payson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant V. Briscoe.
(Address)

15 Filed ..... 19 27 Per ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927 to May 4, 1927, that I last saw him alive on May 4, 1927, and that death occurred, on the date stated above, at 1:15 p. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Bronchopneumonia

(duration) ..... yrs. 1 mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Watts M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Republic, Md.

DATE OF BURIAL May 4 1927

20 UNDERTAKER Arthur A. Hartman

ADDRESS Westminster, Md.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21898 ✓ E 21898

CERTIFICATE OF DEATH.

12-51 90

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2733 Maryland Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Ford

(a) Residence No. 2733 Maryland Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

~~Single~~ ~~Married~~ Widowed, or Divorced (Write the word.): Widowed

5a-If ~~single~~, widowed, or ~~divorced~~ WIFE of Samuel Smith Ford

6-DATE OF BIRTH (month, day and year): ?** ?**1843

7-AGE: 84 yrs. ? mos. ? ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town): Somerset Co.
(State or Country): Maryland

PARENTS.

10-NAME OF FATHER: William Beauchamp

11-BIRTHPLACE OF FATHER (city or town):
(State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Harriet Adams

13-BIRTHPLACE OF MOTHER (city or town):
(State or Country): Unknown

14-
(Informant): Mrs. Chas. Holt
(Address): 3820 Greenmount Ave.

15-
Filed 1927 C. HAMPSON JONES, M. D. Registrar.
Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 3. 1927

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 20 to May 3 19 27
that I last saw h~~er~~ alive on May 2 19 27
and that death occurred, on the date stated above, at 12:25A m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Years mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) E. Earl Holt M. D.
5/3 1927 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: May 5 1927

20-UNDERTAKER: Hughes Jones Inc — ADDRESS: 1st & Riverside

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21899 E 21899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Somerset St 15-64 ST. 129 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Francis Keyser

(a) RESIDENCE NO. 1502 Eutaw Pl & Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 11-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77		32	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harpers Ferry W. Va.

PARENTS

10 NAME OF FATHER Chas Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jefferson Co. Va.

12 MAIDEN NAME OF MOTHER Emily Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harpers Ferry. Va.

14 Informant Chas W. Keyser (Son)
(Address) 1502 Eutaw Pl

15 Filed ....., 19 27 C. HARTMAN JONES, M. D.
Flor. RRW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April 81, 1927, to May 3, 1927, that I last saw h... alive on May 3, 1927, and that death occurred, on the date stated above, at 4 05 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Chronic interstitial nephritis and Senility contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

Pulmonis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Maurice H. Hicks M. D.

, 19 (Address) 904 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harpers Ferry W. Va	May 5 1927
20 UNDERTAKER	ADDRESS
Horace H. Burgee	1615 Fallsway

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21900 ✓ 136 E 21900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 34 N. Ellwood ave St. 6-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Charles Renner

(a) RESIDENCE NO. 34 N. Ellwood ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): april 28 1927

7 AGE — Years: — Months: — Days: ✓ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: George M. Renner

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Helen E. Bender

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md.

14 Informant: George M. Renner

(Address): 34 N. Ellwood ave

15 Filed: 1927 Per: C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927, to May 3, 1927, that I last saw h[illegible] alive on May 3, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Hemorrhage from Penis following Circumcision

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

(Address) 80 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial: May 3 1927

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21901

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21901

1-PLACE OF DEATH U.S. Marine Hospital #1

CITY OF BALTIMORE: (No.) Balt. 2nd. — (St.) 7-4 (Ward)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Julin.

(a) RESIDENCE No. 1632 (Usual place of abode) Fleet St Baltimore, Md. ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? 4 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April - 1892

7 AGE: Years 35 Months 1 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer S/S Munalbro.

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: A. Julin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: A Lundin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Self. (Address)

15 Filed [illegible] 19 [illegible] Registrar

- 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1925, to May 4, 1927, that I last saw him alive on May 4, 1927, and that death occurred, on the date stated above, at 5-30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of larynx

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? U.S. Navy

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings, and laboratory tests.

(Signed) W.W. Benton, M.D.

4A Surgeon U.S.P.H.S.

5-4, 1927 (Address) U.S. Marine Hospital #1 Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: May 5, 1927

20 UNDERTAKER: E L Roy Stiffler — ADDRESS: 1259 North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21902

CERTIFICATE OF DEATH.

90 E 21902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belvista ave (ST.) Hamilton (WARD)

2-FULL NAME Eugene Harker

(a) RESIDENCE NO. Belvista Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John J Harker

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Gladmon

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Wm J Harker
(Address) 1822 Moreland

15 Filed ... 19... C. HAMPSON JONES, M. D.
- 1927 Registrar
By Apell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 22 . 1927 . to May 3 . 1927 .
that I last saw h alive on May 2 . 1927 .
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
& Pulmonary Oedema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteri sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

May 3, 1927 (Address) 4706 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount be

DATE OF BURIAL May 6 1927

20 UNDERTAKER W M Coulson

ADDRESS 2238 W Balto

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21903 — 1-PLACE OF DEATH

31 ✓ E 21903 — REGISTERED NO.

City of BALTIMORE: (No. 751 St. Peter Street St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly B. Morsberger

(a) RESIDENCE NO. 751 St. Peter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 5th. 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
✓	33	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Garden Theatre

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Morsberger

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Dove

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Charles O. Thompson

(Address) 750 St. Peter St.

15 Filed MAY 5 - 1927 C. BAXLEY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 3rd. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1926 to May 3 1927

that I last saw her alive on May 2 1927

and that death occurred, on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH* was as follows:

a Pulmonary Tuberculosis - F

(duration) yrs. 8 mos. 6 da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted -

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mo Trulinger, M. D.

5/3, 1927 (Address) 682 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial May. 6 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N. Balto St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21904 46 ✓ E 21904

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2711 W. Lafayette Ave. St. 1668 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Davidson

(a) RESIDENCE NO. 2711 W. Lafayette Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas C. Davidson

6 DATE OF BIRTH (month, day, and year): January 27, 1887

7 AGE — Years: ✓ 40 — Months: 3 — Days: 5 — IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town): Cambridge

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Rascall Johnson

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sarah E. Tucker

13 BIRTHPLACE OF MOTHER (city or town): E. New Market

(State or country): Maryland

14 Informant: Thomas C. Davidson

(Address): 2711 W. Lafayette Ave.

15 Filed ... 19 ... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th 19 ... to May 2/27 19 ...

that I last saw her alive on May 2/27 19 ...

and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. B. Holt, M. D.

May 3 19 27 (Address) 1203 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: May 5 1927

20 UNDERTAKER: Jos. L. Cook — ADDRESS: 1003 W. Balto St

MAY 5 - 1927 [illegible]

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Guider

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21905

CERTIFICATE OF DEATH.

18-002

E 21905

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 27-54

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Charles E Guider

(a) RESIDENCE NO. Seton Hill ST Washington Blvd WARD Smith Poplar Lane

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53,	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant, 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George C. Guider

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Kate Wheat

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Kate Guider

(Address) 2000 Seton Hill Mt Wash

15 Filed MAY 5 - 1927 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 , 1927, to May 5 , 1927, that I last saw h alive on May 5, 1927, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/3/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount May 5 1927

DATE OF BURIAL

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1600 Eutaw Pl

Spec.–7-17-26—A Co.—200 Bks.

E 21906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 21906

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital

City of BALTIMORE: (No. 1359 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Perkins Hall Marine

(a) RESIDENCE NO. 717 Reservoir St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Mathew Marine

6 DATE OF BIRTH (month, day, and year): ~~Nov~~ Sept. 1845

7 AGE: Years 81 Months 8 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Georges Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard D. Hall

11 BIRTHPLACE OF FATHER (City or town) Prince Georges (State or country) Md.

12 MAIDEN NAME OF MOTHER ~~Susanna~~ Harriet P. Perkins

13 BIRTHPLACE OF MOTHER (city or town) ~~Springfield~~ (State or country) Md.

14 Informant (Address) Miss Harriet Marine Daughter

15 Filed ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to May 3, 1927, that I last saw h alive on May 3, 1927, and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ? yrs. ? mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray examination

(Signed) H. D. Hall, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy. Date of Burial: May 6 1927

20 UNDERTAKER: John O. Mitchell ADDRESS 1900 Eutaw Place

MAY 5 - 1927 C. HARVEY JONES, M. D. Registrar

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21907

CERTIFICATE OF DEATH.

57 E 21907

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Jefferson ST., 7-9 Francis WARD)

2-FULL NAME Ulrich Christiansen.

(a) RESIDENCE NO. 616 Jefferson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant Mrs. Walter Williams
(Address) 616 Jefferson St

Filed MAY 5 - 1927 Registrar [illegible] M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 4, 1927,
that I last saw h[illegible] alive on May 4, 1927,
and that death occurred, on the date stated above, at 3:30 A m.
The CAUSE OF DEATH* was as follows:

Hemiplegia
(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) [illegible] M. D.
May 5, 1927 (Address) 616 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery | DATE OF BURIAL May 7 1927

UNDERTAKER Chris H. Johnson | ADDRESS 446 N. Caroline St.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21908

CERTIFICATE OF DEATH.

66

REGISTERED NO. E 21908

1-PLACE OF DEATH In rear of 101-2-8 St.

City of BALTIMORE: (No. ~~3908~~ 26-37 St., Ward)

2-FULL NAME Fred Berninger

(a) RESIDENCE NO. 3908 E Pratt St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced RUSBAND of (or) WIFE of: Mamie Berninger

6 DATE OF BIRTH (month, day, and year): Nov 4th 1891

7 AGE: Years 35 Months 5 Days 28 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Andrew Berninger

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Heller

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Andrew Berninger

(Address): 3908 E Pratt St

Filed May 5 1927 19 C. HANSON JONES, M. D. Registrar

By R.F.C.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 - 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cirrhosis liver

(Duration) yrs. mos. 1 ds.

May 6 (Signed) C. E. Yates M. D.

(Coroner)

(Address) 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — Date of Burial May 5th 1927

20 UNDERTAKER: Frank V. Pepitone — ADDRESS 2818 E. Baltimore St

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21909

CERTIFICATE OF DEATH

31 E 21909

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (1427) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Smith

(a) RESIDENCE NO. 521 Parrish st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

Filed MAY 5 - 1927 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 6, 27 to May 1, 19 27

that I last saw him alive on May 1, 19 27

and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. Gatteau, M. D.

5-2-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — Date of Burial May 5 1927

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

8

Use typewriter in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21910

CERTIFICATE OF DEATH.

129 E 21910

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1032 Vine St. 18-26 Ward)

2-FULL NAME Fannie Hardman

(a) RESIDENCE NO. 1032 Vine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Col'd	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Hardman

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of indnstry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Robert Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Hardman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Dave Hardman

(Address) 1032 Vine St.

15 Filed....., 19.... Registrar

MAY 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/27 19

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to May 4, 1927, that I last saw h.. alive on May 4, 1927, and that death occurred, on the date stated above, at 9 h. m.

The CAUSE OF DEATH* was as follows:

Chronic Lobar Pneumonia Resolution

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

May 6/27 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial May 7, 1927

20 UNDERTAKER Mrs Katie R. Williams & Schroeder ADDRESS 322

very important. See instructions on back of certificate. EACH STATEMENT OF OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

Halls

E 21911 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. 12-23 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Halls

(a) RESIDENCE NO. 222 E. Montgomery ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 13-1925

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Howard Halls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel County - Md.

12 MAIDEN NAME OF MOTHER: Anna Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rock Hall Md

14 Informant: Mrs Annie Halls
(Address) 222 E Montgomery St

15 Filed 5 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1927, to 5-3, 1927, that I last saw him alive on May-3, 1927, and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumania
Empyema

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Acute bilateral otitis Media

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4/20/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Laboratory

(Signed) Reuel Owens M.D.

(Address) 1 Bal Bal Ga Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hall Md Worthley Company

UNDERTAKER: Chas L Stevens

DATE OF BURIAL: May 6 1927

ADDRESS: 1520 Fort Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21912
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

E 21912
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2206 Booth ST. 20-69 (WARD)

2-FULL NAME John Odsuszlek

(a) RESIDENCE NO. 2206 Booth ST., 20 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of): Magdalena Odsuszlek

6 DATE OF BIRTH (month, day, and year): May 27 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): Hecla Falls Co
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Hungary

PARENTS
10 NAME OF FATHER: Nicholas Odsuszlek
11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary
12 MAIDEN NAME OF MOTHER: Helen Maddla
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Frank Endof
(Address) 2206 Booth St

15 Filed MAY 5 1927 C. HARRY JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased (from) April 27, 1927, (to) May 2, 1927,
that I last saw him alive on May 2, 1927,
and that death occurred, on the date stated above, at 1-0, m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

6
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) I Hello Hemming M. D.
5/4, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 5th 1927

20 UNDERTAKER: F.B. Shipley — ADDRESS: 850 W. Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21913 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21913

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Visitation of Notre Dame St. 10-14 WARD)

2-FULL NAME Mary James Schandelle

(a) RESIDENCE NO. Virginia St and Ashland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April - 19 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	69		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher Gk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Schandelle

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Teresa Ballhorn

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sister M. Dionysia Notre Dame
(Address) Virginia St City

15 Filed 5 1927 C. HAMPSON JONES, M. D.
Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 4 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb - , 1920 , to May - 4 , 1927 ,

that I last saw h[illegible] alive on May - 4 - , 1927 ,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) F. J. Kelly M. D.

5/4, 1927 (Address) 110 E York Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Abd DATE OF BURIAL May 7 1927

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21914

CERTIFICATE OF DEATH.

38

E 21914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp. ST. 8-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley E. Gilbert

(a) RESIDENCE NO. 2803 Mayfield ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	44	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Service

(b) General nature of industry, business, or establishment in which employed (or employer) Letter Carrier

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George E. Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ewing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant George W. Gilbert (Address) 2803 Mayfield Ave.

15 Filed 5 - 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1927, to May 4, 1927, that I last saw h/m alive on May 4, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Syphilis tertiary Immun not given, 7 left Chest (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) P. B. Hagerman, M. D.

, 19 (Address) U. S. Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Harford Co.	May 4. 1927
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford ave

Spec.—1-12-23—M&T—500 Bks.

21915

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21915

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 N. Hafe ~~Ha~~ ST. 4-18 WARD)

2-FULL NAME Alphonse J. McClain

(a) RESIDENCE NO. 1826 N. Hafe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Lif~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb 26/25

7 AGE: Years: ✓2 Months: 2 Days: 6-7 If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Bruce A. McClain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Highfield Md

12 MAIDEN NAME OF MOTHER: Theresa R. Wehner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: A. Bruce McClain

(Address) 1826 N. Hafe St.

Filed MAY 5 - 1927 C. HARRY JONES, M.D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2. 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1- , 1927 , to May 2- , 1927 , that I last saw him alive on May 2 , 1927 and that death occurred, on the date stated above, at 4 P. m

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) probably yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ½ da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. S. Hayden, M. D.

5/5 1927 (Address) 1216 N. Carrollton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hall Pedemont Cemetery

DATE OF BURIAL: May 5 1927

UNDERTAKER: George F. Ruth

ADDRESS: 1735 Hanford Av.

IMPORTANT—See Instructions on Back of Certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-005

E 21916

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1122 N. Montford Avenue St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Brooks

(a) RESIDENCE NO. 1122 N. Montford Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Brooks

6 DATE OF BIRTH (month, day, and year) 3/1/1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Vincent Eckert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Henretta Felty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Louisa E. Hansen

(Address) 1122 N. Montford Ave

15 Filed MAY 5 - 1927 19 J. [illegible] JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to May 3, 1927, that I last saw h.. alive on May 3, 19.., and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhage of

coronary artery (duration) .. yrs. .. mos. 1 ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death? No Date of None.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Lee Hagner, M. D.

5/4. 1927 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: 4/6 27

20 UNDERTAKER: Albert L. Heltz Jr — ADDRESS: 1606 N. Chester S

very important. See instructions on back of certificates. PART SUPPLIED BY UNDERTAKER. PART SUPPLIED BY PHYSICIAN. PART SUPPLIED BY INFORMANT. PART SUPPLIED BY REGISTRAR. PART SUPPLIED BY OCCUPATION IS

Spec.—1-10-21—M&T—1500 Bks.

E 21917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21917

CERTIFICATE OF DEATH.

25-001

REGISTERED NO. 25-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 214 Cedar ST. 25 WARD)

2-FULL NAME Barbara Krejcik

(a) RESIDENCE No. 214 Cedar ST 25 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? 20 yrs. 1 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of Vaclav Krejcik

6 DATE OF BIRTH (month, day, and year) May 23-1861

7 AGE: Years 66 Months 11 Days 10 (65)

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. (37)

(b) General nature of industry, business, or establishment in which employed (or employer): H. W.

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bohemia.

PARENTS

10 NAME OF FATHER: Joseph Havranek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia.

14 Informant: Charles Krejcik.

(Address) 214 Cedar St

15 Filed MAY 5 - 1927 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1927, to May 3, 1927

that I last saw h[illegible] alive on May 2 1927

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 3, 1927 (Address) 1816 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: May 6 1927

UNDERTAKER: Frank Erachton

ADDRESS: 1906 Edmondi

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 21918

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21918

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 325 N. Bruce St. St. 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Earl Williams

(a) RESIDENCE NO. 325 N Bruce St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. 5 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward D. Williams

6 DATE OF BIRTH (month, day, and year): May 10, 1887

7 AGE: Years 39 | Months 11 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Nansmon Co Va

PARENTS

10 NAME OF FATHER: William Benton

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Isabell Sills

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Ed. D Williams (Husband)

(Address): 325 N.Bruce St

C. HAMPTON JONES, M. D.

Registrar

MAY 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 3rd. 1927

17

I HEREBY CERTIFY, That I attended deceased from March 1st 19 27, to May 3rd 1927,

that I last saw her alive on May 2nd 1927 19,

and that death occurred, on the date stated above, at 9.a.m.

The CAUSE OF DEATH* was as follows:

Ch. Pulmonary T.B.C

(duration) yrs. 8 mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lion

Date of Burial: 5-6 1927

UNDERTAKER: Joseph A. Lively

ADDRESS: 409 N Mount St

Be sure and put name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21919 — REGISTERED NO. 21 E 21919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital 27-55 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ezra Van Order

(a) RESIDENCE NO. 15 Cornhill Road ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Van Order

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	76	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloss Bros

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER David Van Order

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Eliz Darley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thomas H. Van Order

(Address) 15 Cornhill Road

15 Filed MAY 5 1927 E. HAMP. JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1927, to May 4, 1927, that I last saw him alive on May 4, 1927, and that death occurred, on the date stated above, at 2:15 a m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bilateral Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

5/4, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL May 6, 27

20 UNDERTAKER Wm. Cook - 502 E. Monument

ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21920

CERTIFICATE OF DEATH.

90 E 21920

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1042 Penna ST.; 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella May Boyd

(a) RESIDENCE. No. 1042 Penna ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John H Boyd

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S C.

PARENTS

10 NAME OF FATHER Richard Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Oliver Jackson

(Address) 1009 Penna ave

15 Filed MAY 5 - 1927 H. [illegible] JONES, M. D. Registrar

Per R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 2, 1927, that I last saw her alive on May 2, 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Woolridge, M. D.

5-2-1927 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn cem May 4 1927

20 UNDERTAKER ADDRESS

Hamil Easton 916 E Pratt

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21921 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 ✓ E 21921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2007 (St.) Oak (Ward) 17-51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Stevens

(a) RESIDENCE NO. 2007 ST. Oak WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45 ✓ Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Jackson Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Ella Coleman

(Address) 2139 Druid Hill Ave

Filed MAY 5 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/3 — 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/25 —, 1927, to 5/3 —, 1927, that I last saw h[illegible] alive on 5/3 —, 1927, and that death occurred, on the date stated above, at 7 1/2 m

The CAUSE OF DEATH* was as follows:

a. Nephritis

x Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Pyelitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Rhutty, M. D.

5/3, 1927 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 6/1927
UNDERTAKER: Hamilton Easton	ADDRESS 915 Eutaw

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21922

CERTIFICATE OF DEATH.

74001

E 21922

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 N. Bradford St St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cloe Williams

(a) RESIDENCE NO. 514 N. Bradford St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonzo Williams

6 DATE OF BIRTH (month, day, and year) July 30/1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40	9	32	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S.C.

PARENTS

10 NAME OF FATHER Isaac Black

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S.C.

12 MAIDEN NAME OF MOTHER Louisa Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S.C.

14 Informant Alonza Williams

(Address) 514 Bradford st.

Filed MAY 5 - 1927 C. HARRY JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension-undetermined

(duration) yrs. mos. ds.

(Signed) [signature], M. D.

(Coroner)

5/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beaufort S. C. Date of Burial May 6 27

20 UNDERTAKER Mack H. Elliott ADDRESS 1725 Eastland Av.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21923

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 21923

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Agnes Hospital St. 14-20 WARD)

2-FULL NAME Joseph Brannon

(a) RESIDENCE No. St Vincents Inf Asylum ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Brannon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant St Vincents Inf Asyl.
(Address) 1401 Division St.

15 Filed MAY 5 - 1927 19 Per K.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-2-, 1927, to 5-4, 1927, that I last saw h(im) alive on 5-4, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
bilateral

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Theron Hunter M. D.

5/4, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	5-5-27
20 UNDERTAKER Martin Fahey Sons	ADDRESS 1827 W North Ave

TION is very important. See instructions on back of certificates.

E 21924 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21924

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH 2925- Mosher St. 7th-001

City of BALTIMORE: (No. 2925 St. Mosher) (Ward) 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis J Petri

(Residence in Baltimore: No. 2925- Mosher St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

6-DATE OF BIRTH. 6 (Month) 6 (Day) 1862 (Year)

7-AGE. 64 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) United Ry + Elec Co.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Jacob Petri

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Do not know

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Petri

(Address) 2925 Mosher St

15-

Filed ..... 192.. .....Registrar.

Per .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

May 4 192.7 (Address) 280 Fremont Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Lorraine Cemetery DATE OF BURIAL. 5-7-27 19

20-UNDERTAKER. Martin Fahey Sons ADDRESS 1827 W Pratt Ave

Very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 21925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21925

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 W. Preston ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Baker

(a) RESIDENCE. No. 504 W. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9 10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Worked home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt. Smith

(Address) 524 N. Poston

MAY 5 - 1927 C. HAMPTON JONES, M. D. Registrar.

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25 - 1926, to May 4 - 1927, that I last saw h[illegible] alive on Apr 30 - 1927, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

Estimated (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none known

— (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. J. Kilby M. D.

5 - 5, 1927 (Address) 222 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cemetery

DATE OF BURIAL May 7 1927

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Eutaw St.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 21926

CERTIFICATE OF DEATH.

E 21926
1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 1525 W.e Cullob St., 14-20 Ward)

2-FULL NAME Valla Jarman

(a) RESIDENCE NO. 1525 W.e Cullob St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Felix Jarman

6 DATE OF BIRTH (month, day, and year): about 1878

7 AGE — Years: 49 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: General

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: Willis Johnson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Helen ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Felix Jarman

(Address): 1525 W.e Cullob St.

15 Filed ..... 19 ..... Registrar

Fee

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary): no history

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 3, 1927 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Suffolk Va

Date of Burial: 5/5 1927

20 UNDERTAKER: Edward Stanley

ADDRESS: 578 W Cullob

MAY 5 1927 H. C. JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Mamie D Thim

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21927

CERTIFICATE OF DEATH.

129

E 21927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lowell's Sanitorium Glenmore Ave. Hamilton (WARD) 27-41

2-FULL NAME Mamie D. Thim

(a) RESIDENCE No. 12 Wilson Heights Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Harry Thim

6 DATE OF BIRTH (month, day, and year) July 21-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Charles A. Fulda

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Christina Feldt

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mr George Fulda

(Address) 12 Wilson Hts ave.

15 Filed ..., 19 C. HA... JONES, M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/1/27, 19..., to 5/4, 19 27, that I last saw h alive on 5/4, 19 27 and that death occurred, on the date stated above, at 3 a. m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyde W. Kelly, M. D.

, 19 (Address) 5012 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 6 1927

20 UNDERTAKER Wm Fickus Sons — ADDRESS Norfolk Va

Spec.—1-12-23—M&T—500 Bks.

E 21928 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15-21 WARD)

2-FULL NAME Joseph B. Mitchell

(a) RESIDENCE NO. 2044 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie Mitchell

6 DATE OF BIRTH (month, day, and year) Oct. 12-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 50

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " " (State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " " (State or country)

14 Informant Annie Mitchell (Address) 2044 N. Fulton Ave

15 Filed MAY 5 - 1927 C. HAMPTON JONES, M. D. Registrar

Per LR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/28/27, 19 . to 5/4/27 . 19 .

that I last saw h/ alive on 5/4/27 . 19 ,

and that death occurred, on the date stated above, at 5-42 A m. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Cardiac Hypertrophy
General Arteriosclerosis
Ch. Pulmonary Tuberculosis (duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Aneurysm (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. S. Winstead M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL May 9 1927

UNDERTAKER Wm J. Tuckner & Sons

ADDRESS N. & Pa

ATTENTION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21929

CERTIFICATE OF DEATH.

135 E 21929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 1637 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Trow

(a) RESIDENCE NO. 3301 1st Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.

6 DATE OF BIRTH (month, day, and year) July 8- 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73		9 11	26 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Copper Worker 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Mary Trow

(Address) 3301 First ave

15 Filed MAY 9 1927, 19 H. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4 1927

17

I HEREBY CERTIFY, That I attended deceased from 5/3, 1927, to 5/4, 1927,

that I last saw him alive on 5/4, 1927,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

Cystitis & Urine Retention

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac Debilitation

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. R. McCall, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetary — DATE OF BURIAL May 7 1927

20 UNDERTAKER George W. Zirkley — ADDRESS 1739 E. Eager St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21930 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 21930

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 O'Donnell St. 16-37 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Helm

(a) RESIDENCE NO. 3401 O'Donnell ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. George Helm

6 DATE OF BIRTH (month, day, and year) Sept. 24-1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred. C. Pabst.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Oswald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Helm.
(Address) 3401 O'Donnell St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to May 3, 1927, that I last saw her alive on May 3, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTOR (Secondary) Cardiac Disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edw. C. Weber, M. D.

5/4/27 (Address) 408 E Bat[illegible] K Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1st Ger. Evang. Cemetery

DATE OF BURIAL May 8 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21931

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21931

CERTIFICATE OF DEATH

118-00

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospitals St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kirby.

(a) RESIDENCE NO. 708 E Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 66- Years Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer - Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER George Kirby

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Dearborn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant

(Address)

15 1827 C. HAMPSON JONES, M. D. Registrar

Per 1326

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-1-27

17 I HEREBY CERTIFY, That I attended deceased from 3-22-, 1927, to 5-1-, 1927

that I last saw h[illegible] alive on 5-1-27, 19

and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

Hemaplegia Right

Thrombosis Right

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-15-27

Was there an autopsy? No

What test confirmed diagnosis? Operation & Physical Signs

(Signed) H. Blackwell M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND MAY 5

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21932

CERTIFICATE OF DEATH.

161-201

E 21932

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 763-W Saratoga St. 4-76 Ward)

2-FULL NAME Infant Hughes

(a) RESIDENCE NO. 763-W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): ~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-4-27

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~

(b) General nature of industry, business, or establishment in which employed (or employer): ~

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER James Hughes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Quitanting S. C.

12 MAIDEN NAME OF MOTHER Lizzie Gray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lawrence, S. C.

14 Informant

(Address)

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-1927

17 I HEREBY CERTIFY, That I attended deceased from 5-4-1927, to 5-4-1927, that I last saw h... alive on 5-4-1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

COMMISSIONER OF HEALTH

MAY 5 - 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 21933

CERTIFICATE OF DEATH.

E 21933
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3473 Foster Ave St., 16-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pancratius (Benny) Gebhardt.

(a) RESIDENCE NO. 3473 Foster Ave. St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25-1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	6.	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. (40)
(b) General nature of industry, business, or establishment in which employed (or employer) Williams Veneer
(c) Name of employer Co.

9 BIRTHPLACE (city or town)
(State or country) Germany.

PARENTS

10 NAME OF FATHER Adam Gebhardt.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.
12 MAIDEN NAME OF MOTHER Katherine Bayer.
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Barbara Gebhardt
(Address) 3473 Foster Ave

15 Filed C. HAMILTON JONES, M. D.
1927 Per KRW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 3 27

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1927, to May 2, 1927, that I last saw h[illegible] alive on May 2, 1927, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

1 Endocarditis
Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted ✓
If not at place of death!
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Heart Murmur
(Signed) [illegible] M. D.
5/3, 1927 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial May. 6 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21934

CERTIFICATE OF DEATH.

10-E 21934

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) 16 (Ward) 37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Lula Bass

(a) RESIDENCE NO. 1031 S. 3rd St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min
	3	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER L. Bass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Barbara Grebner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant L. Bass

(Address) 1031 S. 3rd St

15 Filed 1927 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to May 5, 1927, that I last saw h[illegible] alive on May 5, 1927 and that death occurred, on the date stated above, at 4 15 a m

The CAUSE OF DEATH* was as follows:

Tonsillar, Pharyngeal & Laryngeal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of 5/3/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pos. Culture

(Signed) Myron S. Tull, M. D.

5/5, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL May 6 1927.

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 N. Wolfe St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 021935

CERTIFICATE OF DEATH. Time of Burial limited to 10 A.M. 5.6.27. 191

E 21935

REGISTERED NO. 191

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT (Ward) 11-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ophelia Jones

(a) RESIDENCE NO. 215 West Ware St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1921

7 AGE: Years 6; Months 3 2; Days 4; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: HARRY Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER: Edith Murray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Parents

(Address): JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

15 Filed 1927 By AAA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 4

17 I HEREBY CERTIFY, That I attended deceased from May 2 1927, to May 4 1927, that I last saw h alive on May 4 1927, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Post-diphtheritic paralysis (pharyngeal)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure terminal.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Antrim County — Date of Burial: May 6 1927

20 UNDERTAKER: Robert E. Williams — ADDRESS: 1515 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21936

CERTIFICATE OF DEATH.

E 21936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 21-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Langguth

(a) RESIDENCE NO. 807 Scott St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie A. Langguth

6 DATE OF BIRTH (month, day, and year) March 27 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Koester Bakery.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Langguth.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.

(State or country)

12 MAIDEN NAME OF MOTHER Klunker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hattie Langguth

(Address) 807 Scott St

15 Filed 5-1927, 19 ARW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1927

17

I HEREBY CERTIFY, That I attended deceased from 4-28, 1927, to 5-5, 1927,

that I last saw him alive on 5-5, 1927,

and that death occurred, on the date stated above, at 4 35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test

(Signed) Sheron Hunter M. D.

5/5, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 7, 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21937

CERTIFICATE OF DEATH.

31

E 21937

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 Mc Elderry ST., 5-8 WARD)

2-FULL NAME Olivia Johnson

(a) RESIDENCE NO. 1244 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Harry Johnson

6 DATE OF BIRTH (month, day, and year) June 19, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	10 11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Maria Plummer

13 BIRTHPLACE OF MOTHER (city or town) S.C. (State or country)

14 Informant Harry Johnson (husband) (Address) 1244 Mc Elderry st

15 Filed 5 - 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to May 3, 1927, that I last saw her alive on May 1, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

5/3 1927 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cusbury Cem DATE OF BURIAL 5-6 1927

20 UNDERTAKER Jas Jr. Skinner ADDRESS 1627 E. Monument st

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21938

CERTIFICATE OF DEATH.

129 E 21938

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 S. Lakewood Ave St. 1-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Shaw

(a) RESIDENCE NO. 1110 S. Lakewood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett Shaw.

6 DATE OF BIRTH (month, day, and year) March 28-1848

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	79	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Bato

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Shaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France.

12 MAIDEN NAME OF MOTHER Susan Brooks.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harriett Shaw (Wife)

(Address) 1112 Hanket St.

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 2-1927

17 I HEREBY CERTIFY, That I attended deceased from 4/8/27, to 5/2/27,

that I last saw h. alive on 5/2/27,

and that death occurred, on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Contributory Endocarditis, Arteriosclerosis

Cardiac Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. L. Straub, M. D.

, 1927 (Address) 3325 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt. Carmel Cem. May 6th 1927

20 UNDERTAKER Tilly & Zeiler ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5

Spec.–7-17-26—A Co.—200 Bks.

E 21939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 21939

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1465 S. Ellwood Ave St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Nied

(a) RESIDENCE NO. 1465 S. Ellwood Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Amanda C. Nied

6 DATE OF BIRTH (month, day, and year): Dec. 12/1850

7 AGE: Years 76 Months 4 Days 23 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: George Nied

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Botsch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Susie D. Savage

(Address)

15 Filed ____ 19 ____ C. HARRISON JONES, M. D. Registrar

Per ____

5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 15, 19 27, to May 4, 19 27,

that I last saw h~~im~~ alive on May 4, 19 27

and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: May 7 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21940

CERTIFICATE OF DEATH

47 E 21940

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1929 Bank St. 7-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Schnell

(a) RESIDENCE NO. 1929 Bank St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 9, 1846

7 AGE — Years: 80 Months: 10 Days: 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Schnell

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Not Known

14 Informant: H. Sander Sons

(Address): 1710 Fleet St

15 Filed: C. HARRISON JONES M D Registrar

Per: RKB

5-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to May 4, 1927, that I last saw h[er] alive on May 3, 1927, and that death occurred, on the date stated above, at 8 9, m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Breast)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 8 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Miller, M. D.

5-5, 1927 (Address) 937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: May 7 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

IMPORTANT: The Medical Certificate of Death must be filled by the attending physician, if any, and he should be called upon to fill it. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21941

CERTIFICATE OF DEATH.

101 001

E 21941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12. Willay (Street) Lafayette (WARD) 42

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Mary Mix

(a) RESIDENCE NO. 12. Wilkins av (Street) Lafayette WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo F. Mix

6 DATE OF BIRTH (month, day, and year): Jan 10 1853

7 AGE: Years 73 Months 3 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John H. Ronemus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: A Mary Ronemus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Lena Mix

(Address): 1273 Sargent st

15 Filed MAY 5 1927

16 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25 19 27 to May 5 19 27

that I last saw h alive on May 4 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Schwarzenberg M. D.

, 19 (Address) 11 N. Wilcox st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Landon Park Cemetery. May 9 1927

DATE OF BURIAL

20 UNDERTAKER: Geo F. Rust

ADDRESS: 1235 Harford Ave

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21942

CERTIFICATE OF DEATH.

129

E 21942

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 3609 Liberty Heights Ave. St.) 15-61 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Rider

(a) RESIDENCE NO. 3609 Liberty Heights Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Rider

6 DATE OF BIRTH (month, day, and year): 6/28/1844

7 AGE: Years 83 | Months 10 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

10 NAME OF FATHER W. C. Rider

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Croft

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Do Not Know

PARENTS

14 Informant: Mrs. G. McLaughlin

(Address) 3609 Liberty Heights

15 [illegible] C. HAMILTON JONES, M. D.

5/5 1927 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5/4/27

17

I HEREBY CERTIFY, That I attended deceased from April 5th 1927, to May 4 1927, that I last saw h[illegible] alive on May 3 1927, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Interstitial nephritis

Myocarditis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia. Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. & Laboratory

(Signed) C. Hamilton Jones, M. D.

5/5, 1927 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation Md. Date of Burial: 5/7 1927

20 UNDERTAKER: J. J. Foley & Sons ADDRESS: 1318 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21943

CERTIFICATE OF DEATH.

185

E 21943

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balt City Hospital St. 1251 Ward)

2-FULL NAME Samuel R. Parker

(a) RESIDENCE NO. 1016 Falls Rd St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Feb 25 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) common

(c) Name of employer none lately

9 BIRTHPLACE (city or town)_____

(State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Samuel C Parker

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Mary C. Holland

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Balto Co.

14 Informant Wm Parker

(Address) 1016 Falls Rd.

15 Filed 1927 C. HAMPSON JONES, M. D.

Per RCW Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Surgical Shock following Operation for Compound Fracture of R. Femur Left and Comminuted Fracture of Pubic Ramus

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Comminuted Fracture of R Femur (duration) .....yrs. 3 mos. .....ds.

(Signed) James M Denton M. D. (Coroner)

5 5. 1927 (Address) Your Chance!

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death .....yrs. 3 mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? fell in front of Broadway Manor

Former or usual residence unknown

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Cem. Balto Co. Date of Burial May 7, 1927

20 UNDERTAKER E. L. Stiffler ADDRESS 125 E. North ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21944

CERTIFICATE OF DEATH.

90 E 21944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1117 N. Calhoun ST. 16-23 WARD

2-FULL NAME Chas. Henry Brown

(a) RESIDENCE. NO. 1117 N. Calhoun ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Chas Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) not

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Annie Diggs (Address) 1117 N. Calhoun

15 Filed ... 19... C. HAMPTON JONES, M. D. Registrar

MAY 6 - 1927 Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1927, to May 3, 1927, that I last saw him alive on May 3, 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms Physical signs

(Signed) John E. I. Campbell, M. D.

May 3 1927 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 6 1927
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1420 Mosher

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 21945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 21945

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Orleans St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Jefferson

(a) RESIDENCE NO. 1625 Orleans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years 47 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Richard Molick

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Easter Jefferson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lena Woolford

(Address) 1550 Mace St.

15 Filed MAY 6 - 1927 C. HAMDEN JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 1927 to May 4 1927

that I last saw h[illegible] alive on May 4 1927

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 1 yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Acute Cardiac dilation

(duration) yrs. mos. da.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Fenn, M. D.

, 19 (Address) 38 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

Date of Burial May 8 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1691 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21946

CERTIFICATE OF DEATH.

E 21946

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander FRISBY

(a) RESIDENCE NO. 1718 Barney St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col—

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1926

7 AGE: Years / Months 4 Days / IF LESS than 1 day.....hrs. or.....min.

16 Mos.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md—

PARENTS

10 NAME OF FATHER Chas. Oxford

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Bertha FRISBY

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant: Records.

(Address) JOHNS HOPKINS HOSPIT

15 Filed....., 19..... C. HARVEY JONES, M. D. Registrar

MAY 6 - 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to May 4, 1927, that I last saw her alive on May 4, 1927 and that death occurred, on the date stated above, at 2.9 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) .....yrs. .....mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.....

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. Price, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — Date of Burial: may 6 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21947

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21947

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 220 S Castle St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Shaney

(a) RESIDENCE NO. 220 S Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine M Shaney

6 DATE OF BIRTH (month, day, and year): June 16 1878

7 AGE: Years 48 Months 10 Days 18 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Transfer Business

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John H Shaney

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Grey

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Katherine Shaney

(Address) 220 S. Castle St

15 Filed MAY 6 - 1927 C. HAMPSON JONES, M. D. Registrar

Per R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/1927 19

17 I HEREBY CERTIFY, That I attended deceased from 4/29/27, 19, to 5/4/27, 19 27, that I last saw h alive on 5/4/27, 19 27, and that death occurred, on the date stated above, at 2 20 Pm.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Latimer, M. D.

19 27 (Address) 3328 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: May 7 1927

20 UNDERTAKER: Fullerton

ADDRESS: 202 E Preston

FOR RECORD BE CAREFULLY SUPPLIED. AGE Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks. see letter in file 3/24/27.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 E 22 21948

CERTIFICATE OF DEATH.

129 E 21948 REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSP 15-58

City of BALTIMORE: (No. _____ St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Cohen

(a) RESIDENCE NO. 4113 Park Heights St. Ave Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Roumania

(State or country)

PARENTS

10 NAME OF FATHER Edward Schwartz

11 BIRTHPLACE OF FATHER (city or town): Roumania

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude

13 BIRTHPLACE OF MOTHER (city or town): Roumania

(State or country)

14 Informant: Records.

(Address) JOHNS HOPKINS HOSP.

15 Filed MAY 6 1927 H. ADDISON JONES, M. D. Registrar

Per KK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1927, to May 6, 1927, that I last saw h[illegible]ive on May 16, 1927, and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic hyperplastic arteriosclerosis; hypertension

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dept. Johns Hopkins Hospital, M. D.

5/6, 1927 Address Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel Cem Date of Burial 5/6 1927

20 UNDERTAKER: Sol Levinson & Bro ADDRESS 1127 E Balto St

MAY 6 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 21949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 21949

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3127 Elmora Ave St., 8-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Campbell

(a) RESIDENCE NO. 3127 Elmora Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Campbell

6 DATE OF BIRTH (month, day, and year): Sept 15 1863

7 AGE — Years: 63 — Months: 7 — Days: 19 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Henry Menzel

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Dora Kunz

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Thomas Campbell

(Address) 3127 Elmora ave

15 Filed MAY 6 - 1927 19 C. HINSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4/1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to May 4, 1927, that I last saw h.. alive on May 3 1927, and that death occurred, on the date stated above, at 12 M. P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis - 5 yrs

Chr. Endocarditis - 4 "

" Nephritis 2 "

Hypocarditis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood smear, Auscultation & Urine

(Signed) J M Deed M. D.

May 5 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Cem

Date of Burial: May 7 1927

20 UNDERTAKER: John Ulrich

ADDRESS 2008 Orleans

Must should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21950

10-002

E 21950

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 202 S. Clinton St., 26-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie May Dallenger

(a) RESIDENCE NO. 202 S Clinton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 31-1923

7 AGE: Years 3 Months 11 Days 26

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Adolph F Dallenger

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Elsie M Appler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Adolph F Dallenger

(Address) 202 S. Clinton St

Filed MAY 6 1927, 19 [illegible] Registrar

Per R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): 5/4/1927. 19

17 I HEREBY CERTIFY, That I attended deceased from April 27, 19, to May 4, 19 27,

that I last saw h alive on May 4, 19 27

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Carditis

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos. 9 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5/5, 19 27 (Address) 1520 E 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: May 6 19 27

20 UNDERTAKER: John Ullrich

ADDRESS 208 Orleans

Now should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Le Mott ✓ ✓

E 21951 HEALTH DEPARTMENT—CITY OF BALTIMORE E 21951

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospital St. 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lemott.

(a) RESIDENCE No. 300 Calhoun St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Coal work~~

(b) General nature of industry, business, or establishment in which employed (or employer) United States

(c) Name of employer Post Inspector.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Martin De Mott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Anna E De Mott

(Address) 10 S Calhoun St.

15 Filed MAY 6 1927 C. [illegible] JONES, D. Reg. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/2, 1927, to 5/5, 1927.

that I last saw h was alive on 5/5/27, 19

and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Angina Pectoris

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Autopsy was Done.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) E. R. Miller M. D.

, 19 (Address) Univ Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL ✓/7/1927

20 UNDERTAKER John J Cowan & Son.

ADDRESS 901 Hollins St.

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21952

CERTIFICATE OF DEATH.

E 21952

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 711 W. Lombard (ST.) 4-29 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridie B. Mc. Nally

(a) RESIDENCE NO. 711 W Lombard ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work.
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michaly Mc. Nally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Miss Anna Mc. Nally
(Address) 711 W Lombard St.

15 Filed MAY 6 - 1927 C. [illegible] JONES, M.D. Registrar
Ref. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923 to May 4, 1927.
that I last saw her alive on May 3, 1927.
and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(duration) yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Left Hemiplegia valvular heart disease (duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical Test.

(Signed) Henry E. Ohle, M. D.
May 5 1927 (Address) 1203 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pro Cathedral Cem

DATE OF BURIAL: 5/7/1927

UNDERTAKER: John J Cowan & Son

ADDRESS: 901 Hollins St.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-902 E 21953

E 21953

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby (Boy) Gendarson

(a) RESIDENCE NO. 2438 Lakeview Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	/		/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Gendarson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Elza Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Brest, Rus.

14 Informant

(Address) Hospital

15 Filed MAY 6 - 1927 C. E. [illegible] JONES, M. D. Registrar Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-5-27

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 19 27, to 5-5, 19 27, that I last saw him alive on 5-5, 19 27, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital malformation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Test

(Signed) Harry Weintraub, M. D.

5/6, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: 5/6 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21954 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 904 William ST., 24-33 WARD)

2-FULL NAME Josephine Sauerhoff

(a) RESIDENCE NO. 904 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Walter R Sauerhoff

6 DATE OF BIRTH (month, day, and year) June 11 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Hamden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Josephine Hisky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr William H. Sauerhoff

(Address) 904 William St

15 Filed MAY 5 1927 Per C. R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 28 1926, to May 3 1927, that I last saw her alive on May 2nd 1927, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation

(duration) — yrs. 5 mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Thomas Heibel, M. D.

5/4, 1927 (Address) 224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 6 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

761

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21955

CERTIFICATE OF DEATH.

90 E 21955

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 Rutland Ave St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia G. Ruckle

(a) RESIDENCE NO. 10 35 Rutland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Isaac Ruckle

6 DATE OF BIRTH (month, day, and year) April 9/1861

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	66	0	21 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Howard Co, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. B. Hunsick

(Address) 2 C. H. [illegible] JONES, M D

15 Filed MAY 6 - 1927 16 Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

(Signed) J. H. Pollitt, M. D.

(Coroner)

5/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial May 7 1927

20 UNDERTAKER Wm C Fillat Jr ADDRESS 2534 W Fay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21956

CERTIFICATE OF DEATH

129 E 21956

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2924 Walbrook St 15-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee A White

(a) RESIDENCE NO. 2924 Walbrook St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Annie White

6 DATE OF BIRTH (month, day, and year): October 18 1849

7 AGE: Years 77 Months 6 Days 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. A. White

11 BIRTHPLACE OF FATHER (City or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Annie White (Address) 2924 Walbrook St

15 Filed MAY 5 1927 19 CHARLTON JONES, M.D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 8th, 1927, to May 3rd, 1927

that I last saw him alive on May 3rd, 1927

and that death occurred, on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Chronic Inter. Nephritis with enlarged heart. (duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac C. Dickson, M. D.

19 (Address) 3055 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

Date of Burial: MAY 7 1927 19

20 UNDERTAKER: Geo W Little

ADDRESS 3708 Edmondson Ave

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21957

E 21957

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital 141

CITY OF BALTIMORE: (No.) Coraline & alma ST., 9-11 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME miss Birdie Foreman.

(a) RESIDENCE NO. 2732 Harford Ave. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1884

7 AGE ✓ 42 Years | 5 Months | 12 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hand work

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annarundal Co

PARENTS

10 NAME OF FATHER Edwin F Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annarundal Co

12 MAIDEN NAME OF MOTHER Ida Langville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anarundal Co

14 Informant Mrs. C. O. Gronert.

(Address) 2732 Harford ave.

MAY 6 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/20/27, 1927, to 5/4/27, 1927

that I last saw h alive on 5/4/27, 1927

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Pelvic Inflammatory Disease.

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac dilatation post operative Pleurisy (duration) ..... yrs. ..... mos. 2 wks

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? No operated

What test confirmed diagnosis? Clinical &

(Signed) H. R. Jones Cornell M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL May 7 1927

UNDERTAKER Jr. J. Kerr ADDRESS 1564 Lyndhurst ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 21958

CERTIFICATE OF DEATH.

E 21958

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 S. Curley St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Klemm

(a) RESIDENCE NO. 611 S. Curley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: late Christopher Klemm

6 DATE OF BIRTH (month, day, and year): Apl 28/56

7 AGE: Years 71 | Months — | Days 5 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: John Vaupel

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. John Harddeker

(Address) 132 E Grindon ave

MAY 6 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3/27

17 I HEREBY CERTIFY, That I attended deceased from April 28 19 27, to May 3 19 27, that I last saw her alive on May 3 19 27 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial 5/6 19 27

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Aliceanna St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21959

CERTIFICATE OF DEATH.

REGISTERED NO. E 21959

1-PLACE OF DEATH

City of BALTIMORE: (No. Guynns Falls Guard House) (Ward) 182

2-FULL NAME William E. White Jr

(a) RESIDENCE NO. 547 Oxford St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26th 1912

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. City

PARENTS

10 NAME OF FATHER Wm E. White Sr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Broadway

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Ella White

(Address) 547 Oxford St.

15 Filed MAY 6 1927 19 [illegible] Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry)

find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) In Swimming

(duration) yrs. mos. ds.

(Signed) Thos. B. Hutton M. D.

(Coroner)

May 5th 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 7-1927

20 UNDERTAKER Samuel Easton ADDRESS 916 Cathedral

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21960

E 21960

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE—No. Mt Sinai Hosp (St.) 13-10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bessie Cadden

(a) RESIDENCE NO. 1913 Park Ave St., ... Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/16/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas R Cadden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Boulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Isabelle Cadden 1913 Park Ave

(Address) Next Kin

15 Filed MAY 6 - 1927 19 Per C. Hamilton JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4-21-27, 19 ... to 5-5-27, 19 ..., that I last saw h[illegible] alive on 5-5-27, 19 ..., and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Chronic Nephritis

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) 0 yrs. 0 mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-21-27

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Jno A Thompson M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 7 1927

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec. – 7-27-26 – 200 Bks.

E 21961

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21961

CERTIFICATE OF DEATH

100-081

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 514 W. Conway St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Stanley

(a) RESIDENCE NO. 514 W Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec - 16 - 1926

7 AGE: Years — Months 4 Days 18 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of Indusiry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Stanley

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Clara Harris

13 BIRTHPLACE OF MOTHER (City or town): Baltimore

(State or country): Maryland

14 Informant: Thomas Stanley

(Address): 514 W Conway

15 Filed MAY 6 1927 19 H. J. JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 1927, to 5/4, 1927, that I last saw her alive on 5/4, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia (Primary)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) Dan Francken, M. D.

5/5, 1927 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

Date of Burial: 5, 6, 1927

20 UNDERTAKER: Wm Geo A Hooper

ADDRESS 2406 Conway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21962

CERTIFICATE OF DEATH

10-002

E 21962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4001 Belleview Ave St. 15-63 Ward)

2-FULL NAME Robt. T. Greer

(a) RESIDENCE NO. 4201 Belleview Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11 1917

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	9	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Milton C. Greer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen M. Gardner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Milton C. Greer
(Address) 4001 Belleview Ave

15 Filed May 6 1927, 19
Per
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

May 5, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial May 6, 1927.

20 UNDERTAKER John O. Mitchell & Son ADDRESS Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 6 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21963

CERTIFICATE OF DEATH.

E 21963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1462 (St.) Montpelier St (Ward) 46

REGISTERED NO. 16190

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gardner

(a) RESIDENCE NO. 1462 (St.) Montpelier St (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 2, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) 1462 Montpelier St

PARENTS

10 NAME OF FATHER John Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co., Md

12 MAIDEN NAME OF MOTHER Susy Venier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant father

(Address)

15 Filed 1927, 19 C. HA[illegible] JONES Registrar

by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 3, 1927, that I last saw her alive on May 3, 1927, and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Premature baby, 8 months, Congenital debility,

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Potsarny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Embryological Laboratory — DATE OF BURIAL 19

20 UNDERTAKER: Wolfe & Madison Sts. — ADDRESS

INSTRUCTIONS: Items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-8-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21964

CERTIFICATE OF DEATH.

179 E 21964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 General Hosp. 26-27 Ward)

2-FULL NAME George Cerny

(a) RESIDENCE NO. 5145 O'Donnell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co.

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)

(State or country) Cesko - Slovakia

PARENTS

10 NAME OF FATHER Louis Cerny

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Cesko - Slovakia

12 MAIDEN NAME OF MOTHER Julia Klega

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Cesko - Slovakia

14 Informant Julia Cerny

(Address) 5145 O'Donnell St.

15 Filed MAY 6 1927 C. PAUL JONES, R.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns of body -

Edema of lungs

DURATION: (Primary) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

May 6 192 7 (Address) 1502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Louis Cem. 5-7 192 7

20 UNDERTAKER Jackowski ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21965

CERTIFICATE OF DEATH.

46 E 21965

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. O'Connor

(a) RESIDENCE NO. 1231 Greenmount St. Ave Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Joseph V. O'Connor

6 DATE OF BIRTH (month, day, and year) Sept 24, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Md — Balto.

(State or country)

PARENTS

10 NAME OF FATHER John Smyth

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Annie McGuiffe

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSP.

15 Filed ..... 19 ..... Registrar

By .....

MAY 6 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 5

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927, to May 5, 1927, that I last saw h.. alive on May 5, 1927, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? at Baltimore

Did an operation precede death? yes Date of April 25, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A. L. Faulkner, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: 5/9 1927

20 UNDERTAKER: Henry H. Mears & Son — ADDRESS: 805 N. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21966

CERTIFICATE OF DEATH.

E 21966

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 S. 17th St., 26-37 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick E. Henning

(a) RESIDENCE NO. 512 S. 17th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Henning

6 DATE OF BIRTH (month, day, and year) Sept 4 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	7 ~~63~~	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Manufacturer

(c) Name of employer Harry Sonneborn & Co

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Frederick Henning

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Pirke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Lillian Frizzell

(Address) 512 S 17th St

15 [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Aort. atheroma

(duration) Sudden yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

5/4, 1927 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem Date of Burial May 6 1927

20 UNDERTAKER Chesnoweth & Son ADDRESS 3615 Chestnut Ave

MAY 6 1927

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21967

CERTIFICATE OF DEATH

74-001

E 21967

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 724 Puritan St. St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kerns

(a) RESIDENCE NO. 724 Puritan St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Josephine Kerns

6 DATE OF BIRTH (month, day, and year): Jan 3, 1861

7 AGE: Years 66 Months 4 Days 1

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: James F. Kerns

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Josephine Kerns

(Address): 724 Puritan St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: May 4,

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1927, to May 4, 1927, that I last saw h.i. alive on May 3, 1927, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Indef yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) [illegible] M. D.

, 19 (Address) 850 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden — Date of Burial: May 7 19 27

20 UNDERTAKER: Ehenoweth Sheldon — ADDRESS: 3615 Chestnut Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21968

CERTIFICATE OF DEATH.

101-001

E 21968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 E. Eager ST., 7-13 WARD)

2-FULL NAME William E. Wheeler

(a) RESIDENCE No. 1703 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L.

6 DATE OF BIRTH (month, day, and year) Oct. 21-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James H. Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Hannah A. Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis, Md.

14 Informant Annie L. Wheeler

(Address) 1703 E. Eager St.

15 Filed MAY 6 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17

I HEREBY CERTIFY, That I attended deceased from April-24, 1927, to May 4, 1927, that I last saw him alive on May 4 1927 and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Myocarditis - Toxemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William H. Schwartz, M. D

5/5, 1927 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL May 7 1927

20 UNDERTAKER George W. Zinkler — ADDRESS 1739 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21969

CERTIFICATE OF DEATH.

31

E 21969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 21969
1-PLACE OF DEATH

City of BALTIMORE: (No. 656 Haner St., 22-30 Ward)

2-FULL NAME Mary E Holmes

(a) RESIDENCE NO. 656 Haner St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 Color or Race: Col | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: John Holmes

6 DATE OF BIRTH (month, day, and year): Mar 10 1901

7 AGE — Years: 25 | Months: 5 6 Mos | Days: 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: John W Evans

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Bowers

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md

14 Informant: John W Evans
(Address): 656 Haner

15 Filed ..... 19..... C. LAWSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) .....yrs. 6 mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

1927 (Address) 3325 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooks Calvert Co Md — Date of Burial: May 19 27

20 UNDERTAKER: John H. Toadvine — ADDRESS: 1027 Edmondson Ave

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21970 ✓

E 21970

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2012 Madison Ave St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Jordan

(a) RESIDENCE NO. 2 Stemmers Run Balto. Co. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	20	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Jordan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Chase

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Agnes Jordan

(Address) Balto. Co. Md.

15 1927 C. HAMPTON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest as to (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

a.c. Gastro enteritis
(24 hours before entering
hospital)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) a.c. Dilatation of heart
(duration) four months yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

May 5, 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Stevens Cem May 7 27

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1225 Eastland Ave

Y 6

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21971

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 21971

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St., 15-21 Ward)

2-FULL NAME Baby Bush

(a) RESIDENCE NO. 1629 Westwood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race White Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25, 1927

7 AGE | Years | Months | Days 7 1/2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Bush

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Page

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records

(Address) Johns Hopkins Hospital.

15 Filed MAY 6 1927, 19 C. HAMPSON JONES, M. D.

Per 1330 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1927, to May 2, 1927, that I last saw him alive on May 2, 1927, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

(1) Prematurity

(2) Syphilis?

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Mother's Wassermann Positive

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! NO Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Baltimore Md. MAY 6 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 6 1927

Spec.—12-9-25—A Co.—200 Bks.

E 21972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24101-001

E 21972

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Church Home & Infirmary (Hosp.)

2-FULL NAME Simon Sigmund

(a) RESIDENCE NO. 728 N. Howard St. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen H. Sigmund

6 DATE OF BIRTH (month, day, and year): June 28, 1852

7 AGE — Years: 74 | Months: 10 | Days: 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Albert Sigmund

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Ella Goldschmidt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Helen Sigmund

(Address) 728 N. Howard St.

15 Filed MAY 6 1927 By C. HAMILTON JONES, M. D. Registrar

Per ORB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927 to May 6 1927, that I last saw him alive on May 6 1927, and that death occurred, on the date stated above, at 6 15a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? While in N.Y. city

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

May 6 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cy. Date of Burial: 5/8/1927

20 UNDERTAKER: Laird Sondheim ADDRESS: 1120 W. Mt. Royal Ave

MAY 6 1927

If death occurred in a hospital or institution, the certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21973 E 21973

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2485 Druid Hill Ave, ST. 13-54 WARD)

2-FULL NAME Baby Bradshaw

(a) RESIDENCE NO. 2485 Druid Hill Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Bradshaw

11 BIRTHPLACE OF FATHER (city or town) Durham (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margaret Elkanah Compton

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) North Carolina

14 Informant Margaret Elkanah Bradshaw (Address) 2485 Druid Hill Ave.

15 May 6 1927 Filed MAY 6 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ at Her Birth, May 5, 1927, to ..., 19..., that I last saw her alive on May 5, 1927, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

19 (Address) 1516 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6

Spec.–7-17-26—A Co.—200 Bks.

E 21974

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 21974

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2017 E North ave St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C Rodgers

(a) RESIDENCE NO. 2007 E North ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Geo W Rodgers

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 75 Months Days IF LESS THAN 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John McConnell

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto md

12 MAIDEN NAME OF MOTHER: Elizabeth Buttersby

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): New York.

14 Informant: Wm C Rodgers

(Address): 2007 E. North Ave

15 Filed: 5/6 1927 C. HUNTON JONES, M. D. Registrar

Per: C.F.A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30 1927 to May 5 1927

that I last saw her alive on May 4 1927

and that death occurred, on the date stated above, at 1230A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

Varicose Ulcer L Leg.

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Course

(Signed) Allen A Rosenberg M. D.

(Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemeteries — Date of Burial: May 7 1927

20 UNDERTAKER: Robt J Turner Sr — ADDRESS: 1317 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Y 6 - 1927

Spec.–7-17-26—A Co.—200 Bks.

E 21975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 21975

1-PLACE OF DEATH

REGISTERED NO. 27-53

City of BALTIMORE: (No. Union Memorial Hospital St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Key Compton

(a) RESIDENCE NO. 219 Woodlawn Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 17 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Key Compton (SALLY TAYLOE)

6 DATE OF BIRTH (month, day, and year): May 21 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
63	6	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Purs. Chesapeake Steamship Co

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Barnes Compton

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Sothoron

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: Mrs Key Compton

(Address) 219 Woodlawn Rd

15 MAY 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 5, 1927, that I last saw him alive on May 5, 1927, and that death occurred, on the date stated above, at 5 55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma splenic flexure of colon

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of May 5 1927

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Lewis Alda Paynter, M. D.

, 19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	5/7, 1927

20 UNDERTAKER: Henry H. Mears & Son ADDRESS 805 N Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21976

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21976

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3411 Copley Road (St.) 15-62 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Turnbull Drysdale

(a) RESIDENCE No. 3411 Copley Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Drysdale

6 DATE OF BIRTH (month, day, and year) May 7 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	66	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt - Pipe Foundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Central Foundry Co.

9 BIRTHPLACE (city or town) Louisville (State or country) Ky

PARENTS

10 NAME OF FATHER Wm Drysdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Gloriana M Rad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mary E Drysdale

(Address) 3411 Copley Road

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1927, to May 6 1927, that I last saw h[illegible] alive on May 6 1927 and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical angina

(Signed) John Colvaugh, M. D.

May 8 1927 (Address) 700 N. W. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Indianapolis Ind — DATE OF BURIAL May 8 1927

20 UNDERTAKER H. J. Lieber & Co — ADDRESS Northern

MAY 6 - 1927

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 - E 21977

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 21-29 ST. ..... WARD)

2-FULL NAME Fannie Estelle Buckmaster

(a) RESIDENCE NO. 600 Scott St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Buckmaster

6 DATE OF BIRTH (month, day, and year) Aug 12, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co.

PARENTS

10 NAME OF FATHER Wallace Joy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George Buckmaster

(Address) 600 Scott St

15 Filed MAY 6 1927, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927 to May 5, 1927.

that I last saw her alive on May 5, 1927

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Tons. & Pharyngeal Diphtheria

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult.

(Signed) Myron G. Tull, M. D.

5/6, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 5/7 1927

20 UNDERTAKER [illegible] — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21978 — 25-081 — E 21978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO. 16-31

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) [redacted]

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	? Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Williams

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 1927 C. HAMILTON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to May 5, 1927, that I last saw h.. alive on May 4, 1927 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Senility

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Stooper Lynch M. D.

May 5 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

London Park — May 7 1927

20 UNDERTAKER — ADDRESS

[redacted] Cook — 502 E. [redacted] St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

6

Dr Hornstein 733 E Lexington St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21979

CERTIFICATE OF DEATH

X 129 E 21979

REGISTERED NO.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1204 Carroll St 21-24 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Londa M Harris

(a) RESIDENCE NO. 1204 Carroll St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas A Harris

6 DATE OF BIRTH (month, day, and year): Jan 7 1890

7 AGE: Years 37 Months 3 Days 29 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: John A Parent

11 BIRTHPLACE OF FATHER (City or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Lucy L Johnson

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Thomas A Harris

(Address): 1204 Carroll St

15 Filed ____ C. HERMAN JORDAN, M. D. Registrar

By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1927, to May 5, 1927, that I last saw her alive on May 5, 1927, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH* was as follows:

Chr Parenchymatous Nephritis

(duration) ____ yrs. 3 mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. N. Hornstein, M. D.

5/6, 1927 (Address) 733 S Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: May 9 1927

20 UNDERTAKER: A. Cook — ADDRESS: Govanstown

MAY 6 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21980

CERTIFICATE OF DEATH

E 21980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1926 W. Mulberry St. (Ward) 20-27

2-FULL NAME William Schenkel

(a) RESIDENCE NO. 1926 W. Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Schenkel

6 DATE OF BIRTH (month, day, and year): Nov. 20. 1863

7 AGE: Years 63 Months 5 Days 15 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O R.R.

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Philip Schenkel

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Hochmuth

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Sarah Schenkel

(Address): 1926 W. Mulberry St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 1927 to May 5 1927

that I last saw him alive on May 4 1927

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert W. Cleary M. D.

5/6 1927 (Address) 1001 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interred

Date of Burial: May 9 1927

20 UNDERTAKER: Wilson Co

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Y6 - 1927

C. HAUSMANN JONES, M. D.

RRH

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21981

E 21981

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4202 Springdale Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Wolff

(a) RESIDENCE NO. 4202 Springdale Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Wolff

6 DATE OF BIRTH (month, day, and year): Feb 18 1859

7 AGE: Years 68 Months 2 Days 17

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Richmond

(State or country) Va

PARENTS

10 NAME OF FATHER Max Lazarus

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Estella Hershenow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: M. Snyder

(Address) 4202 Springdale Ave

15 Filed: C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from about 6, 19 26, to May 6, 19 27,

that I last saw h[illegible] alive on May 4, 19 27,

and that death occurred, on the date stated above, at 6:55 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) 0.7 Lenora

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sinai Friendship Cemetery — Date of Burial: May 8 1927

20 UNDERTAKER: J. Aphens & Co

ADDRESS 33 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 6 - 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21982

CERTIFICATE OF DEATH

E 21982

13-59 58-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2040 Brookfield Ave. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Faupel

(a) RESIDENCE NO. 2040 Brookfield Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna H. Faupel

6 DATE OF BIRTH (month, day, and year) July 31, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Jacob Faupel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Loechel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Anna H. Faupel

(Address) 2040 Brookfield Avenue

15 MAY 6 - 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April, 1926, to May 6, 1927, that I last saw him alive on May 6th, 1927, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

about 1 yr. (duration) yrs. mos. ds.

18 Where was disease contracted From-

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

May 6 19 27 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial May 9, 1927

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 6 - 1927

Spec.—1-10-21—M&T—1500 Blks.

E 21983

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 21983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N Dallas St. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard A Davis

(a) RESIDENCE NO. 116 N Dallas St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 23-1910

7 AGE: Years 17 Months 3 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Eleanor Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Davis (Address) 116 N Dallas St

15 Date 5-7-1927, 19 CHARLTON JONES, M. D. Registrar

Ref RPA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to May 5, 1927, that I last saw him alive on May 5, 1927, and that death occurred, on the date stated above, at 7.40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Hamm, M. D.

, 19 (Address) 38 S Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. *(See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery May 8, 19

DATE OF BURIAL

20 UNDERTAKER: Chris. N. Johnson ADDRESS 416 N. Carolina

Y 7

mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 21984

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21984

CERTIFICATE OF DEATH.

100-04

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 815 Sterling St. 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Holmes

(a) RESIDENCE NO. 815 Sterling ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Holmes

(Address) 815 Sterling st

15 Filed MAY 7 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927 to May 5 1927 that I last saw h[illegible] alive on May 5 1927 and that death occurred, on the date stated above, at 6 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchi Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Empirical

(Signed) O. H. Hornstein M. D.

5/6 1927 (Address) 733 Mosquito st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL May 9 1927

20 UNDERTAKER Louis H. Hudson & Co. ADDRESS N. Capitol

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 21985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1419 Fremont ST. (WARD) 14-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Crawford

(a) RESIDENCE NO. 1419 Fremont ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Crawford.

6 DATE OF BIRTH (month, day, and year) May 28-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Charles Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Monora S. Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) James Snowden 1419 Fremont ave

15 MAY 7 - 1927 C. HAMILTON JONES, M. D. Registrar

Per C.H.J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to May 5, 1927, that I last saw h alive on May 3, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pressure Pulmonary Congestion (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

May 5, 1927 (Address) 1204 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL May 7 1927

20 UNDERTAKER John H Owens — ADDRESS 538 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21986

100-001

CERTIFICATE OF DEATH

E 21986

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 834 S. Eutaw St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Quill Tassiter

(a) RESIDENCE NO. 834 S Eutaw St. 21 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 5 1919

7 AGE: Years 8 Months 3 Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Robt Quill

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Ruth Tassiter

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Robert Quill

(Address) 834 S. Eutaw St.

15 MAY 7 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/2/ 1927 to 5/5/ 1927

that I last saw him alive on 5/5/ 1927

and that death occurred, on the date stated above, at 2:06 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Acute (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Recurrent Bronchitis

Pleurisy (duration) about yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

5/5/ 1927 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 5-7 1927

20 UNDERTAKER: John H. Trodden — ADDRESS 10 27 Howard Hall

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 21987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2024 Ellsworth St. 8-17 Ward)

2-FULL NAME Mary Kmunek

(a) RESIDENCE NO. 2024 Ellsworth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Kmunek

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE — Years: 68 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Czechia

PARENTS

10 NAME OF FATHER: Joseph Hajek

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Czechia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Czechia

14 Informant: Mary Zubel

(Address) 2024 Ellsworth St

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

1927 Per R.R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1927, to May 6th, 1927, that I last saw h.er alive on May 6th, 1927, and that death occurred, on the date stated above, at 1240 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? .....

(Signed) H. H. Kerr Hurd M. D.

, 19 (Address) 3006 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery Date of Burial May 9 1927

20 UNDERTAKER: Frank Crockett ADDRESS 1906 Eastwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

M 7 - 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21988

CERTIFICATE OF DEATH.

129 E 21988

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1931 N. Collington Ave. St., 8-16 Ward)

2-FULL NAME Clara May Busch

(a) RESIDENCE NO. 1931 N. Collington Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelius Busch

6 DATE OF BIRTH (month, day, and year) May 30, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Funk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Nettie Overton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Frederick, Md.

14 Informant Cornelius Busch

(Address) 1931 N. Collington Ave.

15 [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

6/6/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial May 9 1927

20 UNDERTAKER John T. Denny ADDRESS 715 Eutaw St

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

W 7 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

21989 E

CERTIFICATE OF DEATH.

21989 E

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 Penna. Ave St. 17-24 Ward)

2-FULL NAME Otis Briggs

(a) RESIDENCE NO. 1001 Penna Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1892

7 AGE: Years 35 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: General

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Isabella Penna

(Address) 1001 Penna Ave

15 MAY 7 1927 C. HAMPSON JONES, M. D., Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) acute tonsilitis

(duration) .....yrs. .....mos. .....ds.

(Signed).....M. D.

(Coroner)

May 6 1927 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion Cem. Date of Burial: May 7 1927

20 UNDERTAKER: Adolphus Halsted ADDRESS 704 N Eutaw St

21. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 21990

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 610 Euclid Ave (ST.) Dist. 10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Conn Alrick

(a) RESIDENCE No. 610 Euclid Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Blair Alrick

6 DATE OF BIRTH (month, day, and year) Nov. 8 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Senior Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Frt. Claim Dept

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) Kent Co (State or country) Md.

PARENTS

10 NAME OF FATHER Lucas Alrick

11 BIRTHPLACE OF FATHER (city or town) Wilmington (State or country) Del.

12 MAIDEN NAME OF MOTHER Matilda Conn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Mary B. Alrick

(Address) 610 Euclid Ave.

15 Filed May 7 1927 C. HAMILTON JONES M. D. Registrar

Per F.A.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 21 1927 to May 5 1927 that I last saw h[illegible] alive on May 5 1927 and that death occurred, on the date stated above, at 5.00 P m

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jason Brailey M. D.

5/7 1927 (Address) 846 W 36 St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL May 9 1927

20 UNDERTAKER Wm J Tucker Sons

ADDRESS Norfolk Va

MARRIED FEMALE, WITH UNFAILING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 7 1927

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21991

CERTIFICATE OF DEATH.

E 21991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 157 St. Ambrose Ave (Street) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Adolph Schmidt

(a) RESIDENCE NO. 157 St. Ambrose Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmidt

6 DATE OF BIRTH (month, day, and year) Feb. 19 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Ins

(c) Name of employer Metropolitan Ins Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Schmidt
(Address) 157 St Ambrose Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1926 to May 5, 1927
that I last saw h[illegible] alive on May 5, 1927
and that death occurred, on the date stated above, at 12.50 [illegible]m

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Zubeck, M. D.

, 19 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: May 19 27

20 UNDERTAKER: W. M. Fuchser Sons

ADDRESS: North Ave

Rev

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21992

E 21992

CERTIFICATE OF DEATH.

74-001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2307 E. Biddle St. 8-12 Ward)

2-FULL NAME Emma Hollenberry

(a) RESIDENCE NO. 2307 E. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Carroll Co. Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Rosa L. Reifsnider

(Address) 2307 E. Biddle St.

15 MAY 7 1927 C. HAMPTON JONES, Registrar

Ref.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1926, to May 6, 1927, that I last saw h[illegible] alive on May 5, 1927, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hemorrhage

Chronic Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? Longwood

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert Singerman, M. D.

5/9, 1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: May 9 1927

20 UNDERTAKER: W. M. Routson — ADDRESS 2238 N. Mon[illegible]

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 21993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 21993

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 532 Orchard St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Gordon

(a) RESIDENCE NO. 532 Orchard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE: 78 Years 75 Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Minnie Brown (Address) 720 Pennsa Ave

15 [illegible] 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4/1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1927, to May 4, 1927, that I last saw h[illegible] alive on May 4, 1927, and that death occurred, on the date stated above, at 11:52 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs 7 mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis about

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Poppiman M. D.

19 (Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millis Wlf St Marys Co — Date of Burial 4/9 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Pa Ave

MAY 7 1927

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21994

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Penna ave ST. 17-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Roberts

(a) RESIDENCE NO. 720 Penna. ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Roberts

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Presser

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mary Gibson

(Address) 720 Penna ave Balto

15 Filed MAY 7 1927 C. HAMPTON JONES, M. D., City Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927 to May 4 1927 that I last saw him alive on May 3 1927 and that death occurred, on the date stated above, at 6.35 A.m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis + Complication Disease (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) Dr. G. W. Kennard, M. D.

5-4 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jacksonville Fla

DATE OF BURIAL 4/7 1928

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pgave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21995

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21995

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

City of BALTIMORE: (No. 2927 W. Lanvale St., 16-67 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary M. Smithson

(a) Residence No. 2927 W. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Thomas F. Smithson

6-DATE OF BIRTH (month, day and year). March 2 - 1854

7-AGE. 73 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Harford Co

PARENTS.

10-NAME OF FATHER. Eliza Scarborough

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Adams.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mrs Rodgers.

(Address) 2927 W. Lanvale.

15- Filed MAY 7 - 1927 C. HAMPSON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26 1927 to May 6 1927 that I last saw h.. alive on May 6 1927 and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Scrotum

(Operating) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) T.O. Fenner

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. K. Allen M. D.

5/7/27 (Address) 2734 W. Lanvale

*Give the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Harford Co. Md. Emory M. E. Church

DATE OF BURIAL. May 7. 1927

20-UNDERTAKER. Geo W Little

ADDRESS 2700 Edmondson Ave

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21996

CERTIFICATE OF DEATH.

E 21996

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Cecil Apartments St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Parr Hooper

(a) RESIDENCE NO. Cecil Apartments St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth 68 yrs. 7 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Hooper

6 DATE OF BIRTH (month, day, and year) October-1-1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Israel M.Parr

11 BIRTHPLACE OF FATHER (city or town) Harford Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Pope

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Maryland

14 Informant Mrs.J.Ross Diggs (sister)

(Address) 1713 Bolton Street

15 Filed MAY 7 1927, 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) yrs mos. ds.

(Signed) H. Blair M. D. (Coroner)

May 6 1927 (Address) 1423 N. Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: May-7-27

20 UNDERTAKER — ADDRESS

STAR.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO... tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 21997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Montpelier ST., 9-46 WARD)

2-FULL NAME Sedonia Heagy

(a) RESIDENCE NO. Rockville, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~(a) HUSBAND~~ of (b) WIFE of Wife of John M. Heagy

6 DATE OF BIRTH (month, day, and year) Aug 3, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71 72	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Rockville, Md.

PARENTS

10 NAME OF FATHER Eldrican Pumphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co., Md.

14 Informant John M. Heagy. (Address) Rockville, Md.

15 Filed MAY 7 - 1927 C. HARRISON JONES, M. D., Registrar. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1927 to May 6, 1927.

that I last saw her alive on May 6, 1927

and that death occurred, on the date stated above, at 11 00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Sybert, M. D.

19 (Address) 1802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockville Town Cemetery	May 7 1927
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 21998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 21998

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1306 Webb (St.) 10-14 (Ward)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hayford

(a) RESIDENCE No. 1306 Webb ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Hayford

6 DATE OF BIRTH (month, day, and year) September 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gust Electric Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophie Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Gertrude Hayford (Address) 1306 Webb St.

15 Filed MAY 7 - 1927, 19 C. HAMPTON JONES, M. D. Per CRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 21, 1927, to May 4, 1927, that I last saw him alive on May 4, 1927, and that death occurred, on the date stated above, at 10:50 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Pulmonary Tb.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical

(Signed) A. L. Hornthein, M. D.

5/6, 1927 (Address) 733 Ausquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL May 5, 1927

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 2-5 Ashland

Spec.—1-10-21—M&T—1500 Bks.

E 21999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 21999

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1342 Dr. Still Ave. ST., 15-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena L. Harris

(a) RESIDENCE NO. 1519 N. Mc Cosky ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Paul J. Harris.

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE 26 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Oliver J. Caulk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Phoebe Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Paul J. Harris
(Address) 1519 N. Mc Cosky St. Balto. Md.

15 1927 C. HARRISON JONES, M. D.
Registrar
Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7th, 1926, to May 3rd 1927.
that I last saw h[illegible] alive on May 3rd 1927.
and that death occurred, on the date stated above, at 2.20 P. m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 10 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Physical

(Signed) [illegible], M. D.
, 19 (Address) 607 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn
DATE OF BURIAL: May 7 1927

20 UNDERTAKER: Samuel T. Hensley
ADDRESS: 1718 N. Bible

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

47

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22000

CERTIFICATE OF DEATH.

146 E 22000

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 W. 36th St. 13-52 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Betty Hitt

(a) RESIDENCE NO. 1502 W 36th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Otis Hitt

6 DATE OF BIRTH (month, day, and year): Aug 24, 1905

7 AGE — Years: 21 — Months: 8 — Days: 12 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Swift Run

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Robert Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Swift Run, Va

12 MAIDEN NAME OF MOTHER: Sarah Lawson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Swift Run, Va

14 Informant: Otis Hitt

(Address): 1502 W 36th St

15 Filed: MAY 7 1927 — C. HAMILTON JONES, M. D. — Per — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to May 6, 1927, that I last saw her alive on May 6, 1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis and Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death! Home

Did an operation precede death! NO Date of

Was there an autopsy! NO

What test confirmed diagnosis! Clinical findings

(Signed) J. H. Wilson, M. D.

, 19 (Address) 873 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkton Va. — Date of Burial: May 7 1927

20 UNDERTAKER: Shenowith & Son — ADDRESS: 3115 Elliott

Spec.-7-17-26—A Co.—200 Bks.

E 22001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22001

CERTIFICATE OF DEATH

86

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 3526 Benson St. St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Livingston.

(a) RESIDENCE NO. 3526 Benson St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 23, 1907

7 AGE — Years: 19 Months: 10 Days: 13

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: James H. Livingston

11 BIRTHPLACE OF FATHER (City or town): md.

(State or country)

12 MAIDEN NAME OF MOTHER: Lula Vogal

13 BIRTHPLACE OF MOTHER (city or town): md.

(State or country)

14 Informant: James H. Livingston

(Address) 3526 Benson St.

15 Filed MAY 7 1927 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 6,

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to May 6, 1927

that I last saw h.. alive on May 5, 1927

and that death occurred, on the data stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Arthritis Deformans

(duration) 17 yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Wass

(Signed) C. H. Campbell M. D.

5/6. 1927 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: May 7 1927

20 UNDERTAKER: Chenowith Olson — ADDRESS: 3615 Chestnut Ave

Spec.-7-17-26—A Co.—200 Bks.

E 22002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22002

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1010 Falls Road St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hoover

(a) RESIDENCE NO. 1010 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Daniel H. Hoover

6 DATE OF BIRTH (month, day, and year) Oct 28. 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	62	6	7 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER John Bond

11 BIRTHPLACE OF FATHER (City or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Painter

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant Daniel H. Hoover

(Address) 1010 Falls Road.

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 5,

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to May 5, 1927, that I last saw her alive on May 1, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Chronic Valv. Heart Dis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edward H. Hooper M. D.

5/7 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Marys Hampden	May 9 1927
20 UNDERTAKER Ehrnowth & Son	ADDRESS 3615 Elmora Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 - 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 E 22003 (679) — E 22003

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (JOHNS HOPKINS HOSP., St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Wilson

(a) RESIDENCE NO. 2307 Bellfield Pa St. Ward Cleveland. Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Flora

6 DATE OF BIRTH (month, day, and year) Apr. 19 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	37		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn

(State or country)

PARENTS

10 NAME OF FATHER Wm H. Wilson

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) ~~Penn~~ Ohio

12 MAIDEN NAME OF MOTHER Julia. —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country) Pa

14 Informant Friends

(Address) JOHNS HOPKINS HOSP.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17

I HEREBY CERTIFY, That I attended deceased from May 2nd 1927, to May 6th 1927, that I last saw h.. alive on May 6th 1927, and that death occurred, on the date stated above, at 1055 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, glioma

(Antecedent)

(duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and autopsy

(Signed) George E. Pfeiffer, M. D.

5/7/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chattanooga Tenn Date of Burial May 7 1927

20 UNDERTAKER A S Marshall ADDRESS 3539 Edmondson Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Y 7

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22004

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22004

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Green St., 4-30 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Burris

(a) Residence No. Elkton City St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 4-25-27

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 40 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Burris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Indiana

12-MAIDEN NAME OF MOTHER, Lottie Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) .....

(Address) .....

15- Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar.

MAY 8 - 1927

MAY 2 - 1927 Per KH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-25-27

17- I HEREBY CERTIFY, That I attended deceased from 4-25 1927 to 4-25 1927

that I last saw h[illegible] alive on 4-25 1927

and that death occurred, on the date stated above, at 5 20 p. m.

The CAUSE OF DEATH* was as follows:

Maternal Syphilis

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Emmet Dodge M. D.

, 19 (Address) Univ. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL ..... 19 ....

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND

UNIVERSITY OF MARYLAND

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

E 22005 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

157 E 22005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Eastern Av ST. 2-4 WARD)

2-FULL NAME Stella Evantowski

(a) RESIDENCE No. 1625 Eastern Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Evantowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Stella Krull

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania

(State or country)

14 Informant John Evantowski

(Address) 1625 Eastern Av

15 Filed MAY 8 1927, 19 HERMAN JONES, M. D. Registrar

K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1927, to May 7, 1927.

that I last saw h alive on May 5, 1927.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Head with Oedema & abscess (External)

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M Delcll M. D.

May 7 1927 (Address) 624 Washington Blvd

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL May 9 1927

20 UNDERTAKER J. W. Ozazewski — ADDRESS 1930 Eastern Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22006

CERTIFICATE OF DEATH.

117 E 22006

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore Gen. 2-4 Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Szymanshy

(a) RESIDENCE NO. 503 S. Bethlehem St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1910

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
16	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country)

PARENTS

10 NAME OF FATHER Walter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Bochnicz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Hospital Record

(Address)

MAY 8 - 1927

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 5th 1927.

17 I HEREBY CERTIFY, That I attended deceased from January 22nd 1927 to May 5th, 1927, that I last saw him alive on May 5th, 1927, and that death occurred, on the date stated above, at 11.50 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Peritonitis

(duration) yrs. 3 mos. 13 ds.

CONTRIBUTORY (Secondary) ruptured appendix

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death! CAT Home

Did an operation precede death! Yes Date of January 22, 27.

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) C. Thomas, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Holy Rosary Date of Burial May 9 1927

20 UNDERTAKER J. W. Zazenski ADDRESS 1930 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22007

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 22007

1-PLACE OF DEATH

City of BALTIMORE: (No. 347 S Fulton Av St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia S. Chaney

(a) RESIDENCE NO. 347 S. Fulton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 29, 1869

7 AGE: 57 Years 6 Months 6 Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Horace Chaney

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Dunall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant S. B. Chaney

(Address) 347 S. Fulton St

Filed MAY 6 1927 C. HAMILTON JONES, M. D. Registrar

Per R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4th 1927 to May 5th 27 1927

that I last saw h Sr alive on May 5th 1927

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) four years yrs. mos da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. S. Small M. D.

5-6 1927 (Address) Arnold Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prince Georges St Barnabas Md

Date of Burial: May 8 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 503 Chatham

18.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22008

CERTIFICATE OF DEATH.

164 E 22008

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2616 Frances St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hannah Maria Ennis

(a) RESIDENCE NO. 2616 Frances St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos P. Ennis

6 DATE OF BIRTH (month, day, and year): Apr. 3rd 1843

7 AGE: Years 84 | Months 1 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: None home

9 BIRTHPLACE (city or town)

(State or country): Somerset Co Md.

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Somerset Co Md

12 MAIDEN NAME OF MOTHER: Rachel Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Somerset Co Md

14 Informant: Mrs Laura Nash (Daughter)

(Address): 555 N Carey St City

15 Filed MAY 8 - 1927

Per L.H. Registrar

(PHYSICIAN) JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 15 1927, to May 7th 1927, that I last saw her alive on May 7 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gradual weakness of heart due to senility

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Old age. No operation because failure of heart & pat's age

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 7, 1927 (Address) 1005 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial May 10 1927

20 UNDERTAKER: H. C. Cook — ADDRESS 502 E Madison

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

22009 E

90 E 22009

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1017 S. Kenwood Ave. Ward 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa A. Miller

(a) RESIDENCE NO. 1017 S. Kenwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Miller

6 DATE OF BIRTH (month, day, and year): Jan 1866

7 AGE: Years 61 Months 4 Days —

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Patrick Curtis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Annie Krause

(Address): 1017 S Kenwood Ave

15 Filed MAY 8 - 1927 19 C. HARRISON JONES, M. D. Registrar

Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: May 5, '27

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1926, to May 5, 1927, that I last saw her alive on May 5, 1927, and that death occurred, on the date stated above, at 1155a m.

The CAUSE OF DEATH* was as follows:

acute Congestion of Lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. E. Burke, M. D.

May 6, 1927 (Address) 7042 Bradwell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dale Cemetery — Date of Burial: May 8 1927

20 UNDERTAKER: Wm Coale — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22010

CERTIFICATE OF DEATH.

45 E 22010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 E. Fort Ave. ST. 24 33 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dempsey.

(a) RESIDENCE. NO. 182 Fort Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred sixty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ambrose Dempsey

6 DATE OF BIRTH (month, day, and year) June 20. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Columbus Welsh.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Ellen Zepp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Mrs. Dempsey. (Address) 182 Fort Ave.

15 Filed MAY 8 1927 C. H. WILLIAM JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 24 1927. to May 6 1927. that I last saw h[illegible] alive on May 6 1927. and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? supposed

(Signed) Wm. T. Seabury, M. D.

5/6, 1927 (Address) 626 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Cem. Granite Md

DATE OF BURIAL 5/9/27 19

20 UNDERTAKER Wm. Cook

ADDRESS 502 E Northern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22011

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 22011

1-PLACE OF DEATH

City of BALTIMORE: (No. 774 Dover St. 27-30 Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Rogers

(a) RESIDENCE NO. 774 Dover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Rogers

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs. Florence Rodgers

(Address) 774 Dover St

15 Filed ..... 19 ..... Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Not Known

(duration) yrs. mos. ds.

(Signed) Leonard J. Wiehn D. (Coroner)

, 19 27 (Address) 3325 Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemtery Date of Burial May 9 1927

20 UNDERTAKER Ernest Pree ADDRESS 1642 W Lafayette Ave

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22012

CERTIFICATE OF DEATH

129

E 22012

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 N. Monroe St. St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fritz

(a) RESIDENCE NO. 518 N. Monroe St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S. if of foreign birth? 84 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Mordecai Fritz.

6 DATE OF BIRTH (month, day, and year) July 1 - 1841

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	85	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Housewife. gn

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Micheal Dotzour

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Edward C. Fritz

(Address) 518 N. Monroe St.

15 Filed MAY 8 1927 C. HOWARD JONES, M. D. Registrar

Per RJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2d, 1927, to May 6, 1927,

that I last saw ~~her~~ alive on May 6, 1927,

and that death occurred, on the date stated above, at 3 20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A Wells Hampson M. D.

5/7, 1927 (Address) 2000 Hallsdale

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Church of God Cemetery-Uniontown Md. Date of Burial: May 9- 1927.

20 UNDERTAKER: Charles J. Schwab ADDRESS: 505 N. Monroe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

Smakum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22013

CERTIFICATE OF DEATH

90 E 22013

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 1037 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Lindheimer

(a) RESIDENCE NO. Balto City Hospital St. Ward

(Usual place of abode) Unknown

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December

7 AGE: Years 75 Months - Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nail

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant City Hosp Records

(Address)

Filed MAY 8 1927 19 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-5-27

17 I HEREBY CERTIFY, That I attended deceased from 4-29 1927 to 5-5- 1927

that I last saw h 9 alive on 5-5- 1927

and that death occurred, on the date stated above, at 11:00 a m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Senescence Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pancreatitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

Date of Burial 5/7 1927

20 UNDERTAKER J J Fahey Sons

ADDRESS Eight O

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22014

CERTIFICATE OF DEATH.

90 E 22014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Earl Court Apartments ST. 11-19 WARD)

2-FULL NAME Julia C. McComas

(a) RESIDENCE No. St Paul & Preston Earl Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of F. F. McComas

6 DATE OF BIRTH (month, day, and year) Dec. 10 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Robert Noble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Eliz. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Eliz. C. Mallonee

(Address) Earl Court

15 Filed MAY 8 1927 19 ... JONES ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1 1927 to May 7 1927.

that I last saw her alive on May 7 1927.

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Chronic Arterio Hypertension

Renal Arterio Sclerosis

Chronic Myocardial Insufficiency

(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1/4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Leland, M. D.

(Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — DATE OF BURIAL: May 9 1927

20 UNDERTAKER: John Ortelchell & Sons — ADDRESS: Hagerstown Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

CERTIFICATE OF DEATH.

E 22015

REGISTERED NO. E 22015

1 PLACE OF DEATH

City of BALTIMORE: (No. 1708 N. Washington St. St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas H. Champness.

(a) RESIDENCE NO. 1708 N. Washington St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Champness.

6 DATE OF BIRTH (month, day, and year): Oct. 22-1845

7 AGE: Years 81 | Months 6 | Days 13 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Joshua J. Champness

11 BIRTHPLACE OF FATHER (city or town):

(State or country): England.

12 MAIDEN NAME OF MOTHER: Lucy Astley.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): England.

14 Informant: Henry Champness (Son)

(Address): 1708 N. Washington St.

15 Filed MAY 8 - 1927 C. HALSEY JONES, M. D. Registrar

Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927, to May 5 1927, that I last saw ~~him~~ alive on May 5 1927, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Arteri o Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? By Exam.

(Signed) M. H. C. Slader, M. D.

May 9 1927 (Address) 1431 W. Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial May 9th 1927

20 UNDERTAKER: Lilly and Zeiler ADDRESS: 403 S. Wolfe St.

—over—

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22016

CERTIFICATE OF DEATH.

90 E 22016

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 28 W. Glen ave ST.) 27-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malki Minnie Friedman

(a) RESIDENCE. NO. 284 Glen Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed or divorced HUSBAND of ~~(or)~~ WIFE of: Samuel Friedman

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE — Years: 68 yrs. — Months: — — Days: — — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 0'7

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Victor Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hilda Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Felix Cohen
(Address) 928 W Glen ave

15 Filed MAY 8 - 1927 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 27.

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 — 1927 to May 7 — 1927

that I last saw h~~er~~ alive on May 7 1927

and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows: Acute insufficiency

CONTRIBUTORY (Secondary) Edema (duration) 4 yrs. mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

5/5/27 (Signed) BM Bergan M. D.

(Address) 3451 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash Road — DATE OF BURIAL: 5/8 1927

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 22017

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22017

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward) 7-26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Pumphrey

(a) RESIDENCE NO. 794 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 58 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labors - 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER Arthur Pumphrey

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ebbeson -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Alice Pumphrey

(Address) 794 W Franklin St.

15 Filed MAY 8 1927 C. HAMPDEN JONES, M. D. Registrar

Per P.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 19 27 to May 4 19 27

that I last saw alive on May 4, 19 27

and that death occurred, on the date stated above, at 6 45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis of Left Knee,

Emaciation (duration) Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) P. S. Elgood M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. Date of Burial May 9 1927

20 UNDERTAKER Leonard Whalen ADDRESS 302-308 Myrtle Ave

IMPORTANT—READ CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22018

CERTIFICATE OF DEATH.

10 E 22018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 12 WARD)

2-FULL NAME Joseph Ernst

(a) RESIDENCE NO. 810 N. Port St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	11	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Blotkamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Henry Ernst (Address) 810 N Port St

15 Filed MAY 8 1927 C. HAMILTON JONES, M. D. Registrar

Per K.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927. to May 7, 1927. that I last saw him alive on May 7, 1927 and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult.

(Signed) Myron G. Tull, M. D.

5/7, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 5/9 1927

20 UNDERTAKER S. D. Ruck

ADDRESS Sykesville

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52

E 22019

CERTIFICATE OF DEATH

E 22019

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1032 Poplar Grove St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Creamer

(a) RESIDENCE NO. 1032 Poplar Grove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White-

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos H. Creamer.

6 DATE OF BIRTH (month, day, and year): Jan 26 1842

7 AGE: Years 85 Months 3 Days 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore (State or country): Md

PARENTS

10 NAME OF FATHER: Jas B. Gardner

11 BIRTHPLACE OF FATHER (City or town): (State or country): Md

12 MAIDEN NAME OF MOTHER: Emily Spry.

13 BIRTHPLACE OF MOTHER (city or town): (State or country): Md

14 Informant: Mrs Birgit Koch (Address) 1032 Poplar Grove St.

15 Filed MAY 8 - 1927 C. HAMILTON JONES, M. D. Registrar

Per R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1926 to May 6 1927, that I last saw her alive on May 6 1927, and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

General Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted? Place of death

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam.

(Signed) John S. Fiatard M. D.

5/7. 1927 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial: May 9. 1927

20 UNDERTAKER: John C. Mitchell ADDRESS: 1900 Eutaw Place

NAME PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22020

100-001

E 22020

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 Harford Ave St. 10-14 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emanuel Woodland

(a) RESIDENCE NO. 725 Harford Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 15/1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	15	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Woodland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Eleanor Dent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Co., Md.

14 Informant Eleanir Woodland

(Address) 725 Harford Ave

15 Filed MAY 8 - 1927 19 C. HARRISON JONES, M. D. Registrar

Per RM

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Terminal) Bronchopneumonia (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Nephritis (Autopsy at Hopkins Hospital) (duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D.
(Coroner)

5/7/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem. Date of Burial May 8, 1927

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 710 Lafayette Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22021

E 22021

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 24 S Chester St 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Kanczewski

(a) RESIDENCE NO. 24 S Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kanczewski

6 DATE OF BIRTH (month, day, and year) Feb 2 - 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	46	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General natnre of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Walter Jankowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Lewandowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Joseph Kanczewski

(Address) 24 S Chester St

15 Filed 19 C. HALSEY JONES, M. D. Registrar

MAY 8 - 1927 Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 6 27

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1927, to 5/6, 19 27.

that I last saw h.. alive on 5/6/27, 19....

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Strahan, M. D.

19 27 (Address) 3328 Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary Cem May 11 1927

20 UNDERTAKER — ADDRESS

John M Weber 1805 Bank

20

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22023

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22022

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Mulberry St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hyde

(a) RESIDENCE No. 1706 Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Hyde

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: 55 Years 5 Months 4 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Emily Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Emma Hyde

(Address): 1706 Mulberry St.

15 Filed MAY 8 1927, 19

C. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927 to May 5, 1927.

that I last saw h[illegible] alive on May 5, 1927,

and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

5-7, 19 27 (Address) 1706 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem

DATE OF BURIAL: 5-9 1927

20 UNDERTAKER: Jas. M. Skinner

ADDRESS: 1625 E. Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22023

CERTIFICATE OF DEATH.

1159-001 E 22023

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip James Smith

(a) RESIDENCE NO. Detroit, Mich. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		2 1/2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Detroit
(State or country) Mich

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wis

12 MAIDEN NAME OF MOTHER Sadie Burn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penn.

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

FILED MAY 18 1927 19 C. HAMILTON JONES, M. D. Registrar

By PRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 7th 1927

17
I HEREBY CERTIFY, That I attended deceased from May 5th 1927, to May 7th 1927, that I last saw h[illegible] alive on May 7th 1927, and that death occurred, on the date stated above, at 7th P. m.

The CAUSE OF DEATH* was as follows:
Hydrocephalus
(duration) yrs. 2/12 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? yes Date of May 7th 1927
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) George E. Tunney, M. D.
5, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Detroit Mich — Date of Burial: 5/8/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22024

CERTIFICATE OF DEATH

E 22024

REGISTERED NO.

90

19-28

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 S. Gilmor St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam S. Bowers

(a) RESIDENCE NO. 310 S. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie E. Bowers

6 DATE OF BIRTH (month, day, and year): May 26, 1838

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	88	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Frederick Co., Md.

PARENTS

10 NAME OF FATHER Adam Bowers

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Ann Boone

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) England

14 Informant Sarah E. Hannon

(Address) 310 S. Gilmor St.

15 Filed MAY 8 - 1927 19 C. HAMILTON JONES, M. D. Registrar

Per K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30th, 1927, to May 7th, 1927, that I last saw h. alive on May 3rd, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) C. E. Nuckols, M. D.

5/7/27 (Address) 130 S. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: May 9, 1927

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 Mate

IF THERE IS A PENCIL PANEL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22025 C 22025

CERTIFICATE OF DEATH.

7/11-001 E 22025

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore St. 24-33, Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Dorsey

(a) RESIDENCE NO. Cooksville Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis Dorsey

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 68 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Maryland

(State or country):

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown.

14 Informant: South Balto. Gen. Hosp.

(Address): 1213 Light St.

15 Filed MAY 9 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 8 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 3rd 1927 to May 8 1927, that I last saw h.. alive on 8th day of May 1927, and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Lyneal Peritonitis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Ruptured Appendix

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of May 4 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) H. C. Miller, M. D.

, 19 (Address) Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cooksville Md Date of Burial May 10 27

20 UNDERTAKER: Speer & Son, Inc. ADDRESS Ellicott City

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 22026

CERTIFICATE OF DEATH.

E 22026

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Clifton Park High Sch[illegible] St. 27-52 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. Stanley Kirkpatrick

(a) RESIDENCE NO. 112 Goodwood Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Feb 27 1912

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	15	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) Jr. High School

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Martyland

PARENTS

10 NAME OF FATHER William Kirkpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Virgie H. Zepp

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Walter Kirkpatrick

(Address) 112 Goodwood Road

15 Filed MAY 9 - 1927 C. HARRISON JONES, M. D. Registrar

Per J.K.C.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/27 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial failure following Influenza 3 weeks previous

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Bates M. D.

(Coroner)

5/7/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial 5-9 1927

20 UNDERTAKER Robert Brooks & Son ADDRESS Baltimore Hollins st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E. 22027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 22027

REGISTERED NO.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hosp. (St.) 9-18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Wettemann

(a) RESIDENCE NO. 1127 E North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1849

7 AGE: 78 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany (State or country)

PARENTS

10 NAME OF FATHER: John Wettemann

11 BIRTHPLACE OF FATHER (City or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Theresa -

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Geo Wettemann (Address) 1127 E. North Ave

15 Filed MAY 9 - 1927 C. HAMPTON JONES, Registrar By D. Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May ~~April~~ 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927 to May 7, 1927

that I last saw him alive on May 6, 1927

and that death occurred, on the date stated above, at 6 1/2 a m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Chronic Tuberculosis of Kidney

(duration) Unknown

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Autopsy

(Signed) S. Bayne-Jones M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: May 9 1927

20 UNDERTAKER: Wm J Tickner & Sons ADDRESS: N. Y. Pa

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22028 — REGISTERED NO. E 22028

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 667 Stirling St., 10-14 Ward)

(If not in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jackson

(a) RESIDENCE NO. 667 Stirling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Boy

(b) General natore of Indostry, business, or establishment in whieh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) V. a

(State or country)

PARENTS

10 NAME OF FATHER Edward Jackson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) V. a

12 MAIDEN NAME OF MOTHER Elizebeth Smith

13 BIRTHPLACE OF MOTHER (city or town) V. a

(State or country)

14 Informant Robert Estbridge

(Address) 223 N. Ann St

15 Filed 5-9-1927 C. H. [illegible] JONES, M. D. Registrar

Per R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-1927

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to May 6, 1927, that I last saw him alive on May 6, 1927, and that death occurred, on the date stated above, at 8 50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein M. D.

5/9, 1927 (Address) 733 a. pratt st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Laurel Cemetery	May 10 1927
20 UNDERTAKER Edward Bryson	ADDRESS 1631 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MY 9 - 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22029

100-001

CERTIFICATE OF DEATH.

E 22029

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted]

City of BALTIMORE: (No. _____ St., 2 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Meldrum

(a) RESIDENCE NO. 811 E. Broadway St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Scotland

PARENTS

10 NAME OF FATHER Andrew Meldrum

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Agnes ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed MAY 6 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to May 7, 1927, that I last saw h[redacted] alive on May 7, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lumbalgy

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) Stanley Smith, M. D.

May, 19 27 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial May 10 1927

20 UNDERTAKER John B. Spence ADDRESS 1325 E. Caroline St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22030

CERTIFICATE OF DEATH

49 E 22030

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert Sts St., 16-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elsie S. Eagleston

(a) RESIDENCE NO. 2421 Arunah St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Mar. 7, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	34	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER George Eagleston

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine McCarr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hospital Records

(Address) Union Memorial Hospital

15 Filed MAY 7 - 1927 19 C. H. S. JONES

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 1927 to May 7, 1927

that I last saw her alive on May 7, 1927

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓

if not at place of death? ✓

Did an operation precede death? Yes Date of May 4, 1927

Was there an autopsy? Partial Autopsy

What test confirmed diagnosis?

(Signed) J. Eagleston M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem Date of Burial 5/10/ 1927

20 UNDERTAKER Phillips & Sons ADDRESS 200 E Oliver St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-9-25—A Co.—200 Bks.

E 22031

E 22031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 22031

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3815 Gough St. 3-4 Ward)

2-FULL NAME Wilhelmine Schlimm

(a) RESIDENCE NO. 231 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Geo. L. Schlimm

6 DATE OF BIRTH (month, day, and year): Apr 18 1861

7 AGE: Years 66 | Months — | Days 18 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Henry Beck

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Geo. L. Schlimm

(Address) 231 S. Bond St.

15 Filed ....., 19..... C. HARRY JONES, Registrar

MAY 9 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6/27

17 I HEREBY CERTIFY, That I attended deceased from 4-30, 1927, to 5-6, 1927,

that I last saw h[illegible] alive on 5-6-27, 19....,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? —Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. J. Frame M. D.

5/7, 1927 (Address) 1929 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial 5/9 1927

20 UNDERTAKER: Philip Henry Allen ADDRESS 2016

DO NOT write in spaces not supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

202624

E 22032

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-003

E 22032

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Wittenberg

(a) RESIDENCE NO. 1517 W. Chapel St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) 3-25-89

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
37	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Jerge Halpenny

11 BIRTHPLACE OF FATHER (city or town) Germ.

(State or country)

12 MAIDEN NAME OF MOTHER Helen Knitz

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

Filed MAY 9 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1927, to May 6, 1927, that I last saw her alive on May 6, 1927, and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage + shock from traumatic Rupture of Uterus

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Primary rupture of uterus at site of corneal pregnancy 1 mos. or more

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? yes Date of 5/5/27

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. K. Warner, M. D.

5/6. 1927 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem Date of Burial 5/7 1927

20 UNDERTAKER Philip Lewis ADDRESS Orleans St.

Filed MAY 9 - 1927 Registrar

Fee

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22033

CERTIFICATE OF DEATH.

176 E 22033

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 76-2 Ward)

2-FULL NAME ~~Seitz~~, William Seitz

(a) RESIDENCE NO. 3 S. East Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Seitz

6 DATE OF BIRTH (month, day, and year) Mar 11 73

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	54	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER John Seitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Barbara Seitz

(Address) 3 S. East Ave

15 Filed MAY 9 1927 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 27 19

17 I HEREBY CERTIFY, That I attended deceased from May 6 19 27, to May 7, 19 27,

that I last saw him alive on May 7, 19 27,

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of May 6, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Clark Grove, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Mathews Cem	5/10 1927
20 UNDERTAKER Philip Herwig	ADDRESS 2006 Eastern Ave

Let nurse be certain supplies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ C

E 22034 DEATH — REGISTRATION NO. **E 22034**

City of BALTIMORE: (No. Sinai Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Hack

(a) RESIDENCE NO. 139 N. Collington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Hack

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Morris Hack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Chana Hack

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Ida Hack

(Address) 138 N. Collington Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/5/ 1927, to 5/8/ 1927, that I last saw him alive on 5/8/ 1927, and that death occurred, on the date stated above, at 3.05 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular disease & chronic nephritis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute suppression of kidneys & uremia

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) John A. Kolb, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mortimer Arch Cem 5/9 1927

20 UNDERTAKER — ADDRESS

Jack Lewis 1439 E Baltimore

Per

Use ink in entering supplies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22035 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Aisquith ST., 9-18 WARD)

REGISTERED NO. 1012

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Smith

(a) RESIDENCE NO. 1414 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward H. Smith

6 DATE OF BIRTH (month, day, and year) Oct 26, 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
27	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Francis Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rosalie Rowels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Husband, Edward H. Smith (Address) 1414 Aisquith St.

15 Filed MAY 9 - 1927 R. E. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 30th, 1927, to May 7, 1927, that I last saw her alive on May 7, 1927, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Manning M. D.

5-7-1927 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 10, 1927
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22036

CERTIFICATE OF DEATH

90

E 22036

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 827 China St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Nier

(a) RESIDENCE NO. 827 China St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 39 Months — Days —

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Transfer

(b) General nature of industry, business, or establishment in which employed (or employer): business

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland.

PARENTS

10 NAME OF FATHER: Edward Nier

11 BIRTHPLACE OF FATHER (City or town): —

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Estella ——

13 BIRTHPLACE OF MOTHER (City or town): Baltimore

(State or country): Maryland.

14 Informant: Sister Johnson

(Address): 827 China

15 Filed MAY 9 1927 19 Per RR Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1927, to 5/5, 1927, that I last saw him alive on 5/5, 1927, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Terminal Uraemia)

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary): " Rheumatism "

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Dan Francheim, M. D.

5/6, 1927 (Address) 22 W. Lex St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem

Date of Burial: 5/9, 1927

20 UNDERTAKER: Mrs Grof A Hooper

ADDRESS 406 W Conway St

Also should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr. Edward Nathan Parkane

E 22037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9-4-001

E 22037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. 5220 Florence Ave 27-55 WARD)

2-FULL NAME Margaret Moore

(a) RESIDENCE No. 5220 Florence Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Moore

6 DATE OF BIRTH (month, day, and year) Sept 7, 1853

7 AGE 63 Years 64 Months 8 Days ..... If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER William Keneban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Keneban

(Address) 5220 Florence Ave

15 Filed MAY 9 1927 H. M. JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to May 7, 1927, that I last saw h[illegible] alive on May 7, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physician's opinion

(Signed) Irvin Eberly, M. D.

May 8 1927 (Address) 700 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL May 9 1927

20 UNDERTAKER William Cahill — ADDRESS 502 E Biddle St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Seabury. 636 E Fort Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 22038

REGISTERED NO. E 22038

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1516 W. Washington ST. 8-17 WARD)

2-FULL NAME Frieda Melde

(a) RESIDENCE No. 1516 N. Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Melde

6 DATE OF BIRTH (month, day, and year) June 1. 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	23	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Fulton Md.

10 NAME OF FATHER Lenord Lay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Diesel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lenord Lay (Address) 1516 N Washington St

15 Filed MAY 9 1927 19 For [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15 1927 to May 7 1927.

that I last saw her alive on May 7 1927.

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual.

(Signed) Lt. J. D. Calvary, M. D.

May 9. 1927 (Address) 636 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL May 10 1927

20 UNDERTAKER Wilson Coh ADDRESS 502 E Monroe

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Gilmer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22039

CERTIFICATE OF DEATH.

90

E 22039

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Gilmer

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER George Blackwell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Harcum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

Filed MAY 9 1927, 19 C. HERTSON JONES, M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

May 7th

17

I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h.e.r alive on May 6, 1927,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis Pneumonia

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 7, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery Date of Burial May 9 1927

20 UNDERTAKER Jos Jourdans Son ADDRESS 2175 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

E 22040

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22040

101-601

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 14 Lorena Ave:

CITY OF BALTIMORE: (No.) Hamilton ST. 47-42 (WARD)

2-FULL NAME George S. Morris

(a) RESIDENCE NO. 14 Lorena Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Morris.

6 DATE OF BIRTH (month, day, and year): 24-19-1873

7 AGE: Years 53 Months 7 Days 18 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Ephraim B Morris.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Martha Morris

(Address) 14 Louise Ave Hamilton

15 Filed MAY 3 1927 C. ELMER JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/7 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 19 27, to 5/7, 19 27.

that I last saw him alive on 5/7, 19 27

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted? H

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Keller, M. D.

, 19 (Address) 5012 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 9th 1927

20 UNDERTAKER: Charles F Evans & Son

ADDRESS 118 E Oliver Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22041 40 E 22041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson Maxwell

(a) RESIDENCE NO. 1111 David Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col. Yellow

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1884

7 AGE: Years 42 Months 9 Days 11 (21) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Havana Cuba

PARENTS

10 NAME OF FATHER: Alfred Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): London Eng.

12 MAIDEN NAME OF MOTHER: Phinizy Pickis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant (Address): Hospitals

15 Filed MAY 3 1927 19 P.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to May 6, 1927.

that I last saw h/M alive on May 5, 1927.

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Unilateral Epithelioma Penis with Secondary Abscess (NB)

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Extravasation of urine & Cellulitis & Gangrene (duration) 3 yrs. mos ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of 4-27-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos A. Young M. D.

, 19 (Address) Jelliffe Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL 5-9 1927

20 UNDERTAKER: Geo. T. Ellwanger ADDRESS 785 W. H

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 22042

CERTIFICATE OF DEATH.

REGISTERED NO. E 22042

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 505 Laurens St. 14-20 Ward)

2-FULL NAME Ora Jones

(a) RESIDENCE NO. 505 Laurens St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Jones

6 DATE OF BIRTH (month, day, and year): August 4 - 1881

7 AGE: 45 Years | Months: 9 | Days: 3. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Frank Howard

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Wm H. Jones

(Address): 505 Laurens St

Filed MAY 9 1927 No. HAMPTON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 14 1927, to May 7, 1927, that I last saw h[er] alive on May 6, 1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Carcinomata (Peritoneal)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. McCard, M. D.

5/9 1927 (Address) 2005 Hillen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial: Mt Auburn May 5 = 9 1927

20 UNDERTAKER: Geo T. A. Gibbs | ADDRESS: 1735 W. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 22043
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 22043
REGISTERED NO.

City of BALTIMORE (No. 1206 N. Collington Ave St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina E. Danz

(a) RESIDENCE NO. 1206 N Collington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 7/12/1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry P. Danz

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sophia Gerdes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore Md.

14 Informant Mrs. Henry P. Danz

(Address) 1206 N Collington Ave

15 Filed ..... 19 .....

Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from November 14 1926, to May 7, 1927, that I last saw h[illegible] alive on May 6, 1927 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Wilhelmina E. Danz, M. D.

5/7/ 1927 (Address) 1613 E Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

Date of Burial: 5/10 1927

20 UNDERTAKER: Albert L Hilty Jr

ADDRESS: 1606 N Charles St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22044

CERTIFICATE OF DEATH.

129 E 22044

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Glenwood av ST. 27-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth B. Goldbeck.

(a) RESIDENCE NO. 629 Glenwood av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry F. Goldbeck.

6 DATE OF BIRTH (month, day, and year) August 9. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Harbeck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gustav Goldbeck.

(Address) 629 Glenwood av.

15 Filed MAY 9 - 1927 G. HERBERT JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1925, to May 6th, 1927,

that I last saw her alive on May 6th, 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. M. Duncan, M. D.

May 7, 1927 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery. DATE OF BURIAL May 11 1927

20 UNDERTAKER George J. Rieth ADDRESS 1735 Hayford

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22045 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 45

E 22045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 4-25 Ward)

2-FULL NAME May Buckingham

(a) RESIDENCE NO. 417 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 1878

7 AGE: Years 48 (~~49~~) Months 11 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER James R Buckingham

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Anna E Buckingham

(Address) 417 W. Mulberry St

15 Filed MAY 9 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/27. 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/7/ , 19 , to 5/7/27. 1927

that I last saw h alive on 5/7/27 , 1927

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Private

(Signed) H R. McCulloh, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 11 1927

UNDERTAKER: Geo L Reuth — ADDRESS: 1735 Hoffman

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22046

CERTIFICATE OF DEATH.

129

REGISTERED NUMBER E 22046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 McCulloh St. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jane Jackson

(a) RESIDENCE No. 2544 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C Jackson

6 DATE OF BIRTH (month, day, and year): April 16, 1865

7 AGE — Years: 62 — Months: 0 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Self,

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: Henry Primrose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Anna Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co,

14 Informant: Harriet E Bell
(Address) 2350 McCulloh

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 6, 1927, that I last saw h alive on May 5, 1927 and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diffuse Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

(Address) 1704 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: 5/9 1927

20 UNDERTAKER: Samuel Hensley — ADDRESS: 1 Eddie

MAY 9 - 1927

EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 E 22047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Biddle ST. 17-24 WARD)

2-FULL NAME Hermella Smith-Dail

(a) RESIDENCE NO. 526 N. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Dail

6 DATE OF BIRTH (month, day, and year) Jan. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Cook

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mamie C. Hobbler

(Address) 2311 Whitelock St. JONES, M

15 Filed MAY 9 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24 . 1927 . to May 6 . 1927 .

that I last saw h[illegible] alive on " " . 1927 .

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Abdominal Cancer

about two yrs.

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Very large myoma

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Physician

(Signed) Arthur Ellis. M. D.

5/6 . 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL 5/9 1927

20 UNDERTAKER Samuel Knusby ADDRESS N Bdle St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22048

CERTIFICATE OF DEATH.

174

E 22048 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq Hosp (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Caplan

(a) RESIDENCE NO. 238 So. Stricker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 30 1923

7 AGE: Years 3 Months 11 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Benj. Caplan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Ettelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Benj. Caplan

(Address) 238 So. Stricker St

15 Filed 19

Per

Registrar

CORONER'S CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) May 8th, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned accidental - Playing with matches

(duration) yrs. mos. 17 hrs

Set self on fire

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.

(Coroner)

May 9th, 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse Side for additional Items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern

Date of Burial: 5/9 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore

MAY 9 1927 C. HAMPSON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—4 Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 22049

REGISTERED NO.

E 22049

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Hunter

(a) RESIDENCE NO. 1612 W Lexington St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Hunter

6 DATE OF BIRTH (month, day, and year) 1-22-1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER Isaac Hunter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Julia Hunter

(Address) 1612 W Lexington St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAY 9 - 1927 Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 — 1927, to May 6 — 1927, that I last saw h— alive on May 6 — 1927, and that death occurred, on the date stated above, at 11-16a m.

The CAUSE OF DEATH* was as follows:

Cardio - Renal Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiodilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E Jones, M. D.

5-7, 1927 (Address) 1445 N Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn	May 9 1927
20 UNDERTAKER	**ADDRESS**
Sam'l W. Chase Sons	1400 Myrtle Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22050

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22050

CERTIFICATE OF DEATH

REGISTERED NO. 77

1-PLACE OF DEATH

City of BALTIMORE: (No. 1553 Leslie St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Crawford

(a) RESIDENCE NO. 1553 Leslie St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race Col

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 - 87

7 AGE Years 40 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S. C.

(State or country)

PARENTS

10 NAME OF FATHER Jack Crawford

11 BIRTHPLACE OF FATHER (City or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Hester Taylor

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant Roxanna Crawford

(Address) 1553 Leslie St

Filed MAY 9 - 1927 H. HANSON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to May 6, 1927, that I last saw h[illegible] alive on May 6, 1927 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Amentia Depression & Psychoses

(duration) yrs. mos ds.

CONTRIBUTORY Dr

(Secondary)

(duration) 4 yrs. mos ds.

18 Where was disease contracted ✓

if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) D. N. Hatcher M. D.

5/8, 1927 (Address) 1115 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakraw S. C. Date of Burial May 9 1927

20 UNDERTAKER Sam'l Chase Hen ADDRESS Mon Market

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22051

CERTIFICATE OF DEATH.

E 22051

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 McHenry St. St. 19-28 WARD)

REGISTERED NO. 65002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Marie Brennan.

(a) RESIDENCE No. 1503 McHenry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	CHILD

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7th. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work CHILD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John T. Brennan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) W Va.

12 MAIDEN NAME OF MOTHER Agnes Graning

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant John T. Brennan
(Address) 1503 McHenry St.

15 Filed MAY 9 - 1927 17 C. H. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17

I HEREBY CERTIFY, That I attended deceased from April 25 1927 to May 7 1927.

that I last saw her alive on May 6 1927.

and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Hodgkins Disease

(duration) About 2 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Henry Cohn M. D.

May 7 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	5/10/27
UNDERTAKER	ADDRESS
Harry A. Dietz & Son	534 W. Lombard St.

Note—This is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22052

CERTIFICATE OF DEATH.

90 E 22052

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 13 Ward)

2-FULL NAME John Lamparski

(a) RESIDENCE NO. 2337 Jonahue Court St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 45 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Lamparski

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) [illegible] Records

Filed MAY 9 - 1927 C. HENRY JONES, M. D. Registrar

Per R/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927, to May 7, 1927, that I last saw him alive on May 7, 1927, and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Cutneal Sclerosis

Myocardial hypertrophy and

Ethan Hicenty

(duration) 7 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ___ yrs. ___ mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gunical & laboratory

(Signed) R. Hooper Lovett, M. D.

May 7 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. Date of Burial May 10 1927

20 UNDERTAKER M. F. Lodowski. ADDRESS 705 S. Ann St

Do not fill in plan terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 22053

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 V

E 22053

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No St. Elizabeth's Home Summit Hillsdale ST. 9-47 WARD)

(If death occurred in a hospital or institution, give ITS NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Nance (NANCE)

(Residence in Baltimore: No. St. Elizabeth's Home St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Negro

5-SINGLE, MARRIED WIDOWED OR DIVORCED (If so write the word): Single

6-DATE OF BIRTH: May (Month) 8 (Day), 1926 (Year)

7-AGE: 0 11 29 — 1 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Paul Nance

11-BIRTHPLACE OF FATHER (State or country): North Carolina

12-MAIDEN NAME OF MOTHER: Ida Nance

13-BIRTHPLACE OF MOTHER (State or country): North Carolina

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Nance

(Address) 317 W Hoffman St

15- MAY 9 - 1927 Filed ..., 191.. Per C. HARRISON JONES, M. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 7 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April, 1927, to May 7 1927, that I saw h~~im~~ alive on May 7, 1927, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ... yrs. ... mos. 21 ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) ... yrs. ... mos. 5 ds.

(Signed) Frank J. Ayd M. D.

May 8, 1927 (Address) 2005 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. In the ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: May 9 ..., 1927

20-UNDERTAKER: Herbert Johnson

ADDRESS 916 Penna Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22054

CERTIFICATE OF DEATH.

199 E 22054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 700 WARD)

2-FULL NAME Mrs Margaret Cook.

(a) RESIDENCE NO. 2727 Wilkens Ave ST. ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 1 mos. ... ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Cook

6 DATE OF BIRTH (month, day, and year) Mar 30th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
27	—	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Stacy R. Nally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Veronica Clemmens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Cook (Address) 2727 Wilkens Ave

15 Filed MAY 9 1927 C. HARRISON JONES, M.D. Registrar Per K.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7- 1927

I HEREBY CERTIFY, That I attended deceased from 5-3, 1927, to 5-7, 1927, that I last saw her alive on 5-7, 1927, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency following septicaemia from self-induced abortion complicated by broncho-pneumonia (duration) ... yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Tests

(Signed) J. Theron Hunter M. D.

1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cathedral Cemetery DATE OF BURIAL May 10 1927

20 UNDERTAKER F. B. Wisnet ADDRESS 1850 N. Bond St

Suicidal Abortion

Spec.—1-12-23—M&T—500 Bks.

E 22055 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 75-12 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Loper

(a) RESIDENCE NO. Dividing Creek NJ ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Loper

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None given

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer — — — —

9 BIRTHPLACE (city or town) (State or country) NJ

PARENTS

10 NAME OF FATHER not give

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant brother- Lewis Loper

(Address) Dividing Creek NJ

Filed MAY 9 - 1927 19 C. HARRISON JONES, Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-12, 1927, to 5-9, 1927, that I last saw him alive on 5-9, 1927, and that death occurred, on the date stated above, at 3:05 p m.

The CAUSE OF DEATH* was as follows:

Sarcoma - Rt. Leg. with Metastasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes, Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical - microscopic.

(Signed) A. J. Knapp, M. D.

5-9, 1927 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del

DATE OF BURIAL May 11 1927

UNDERTAKER Wm. Hiss & Son

ADDRESS 25 E. 23rd St. City

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22056

CERTIFICATE OF DEATH.

8 E 22056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 N. Calvert St. 12-19 WARD)

2-FULL NAME Antoinette G. Bell

(a) RESIDENCE NO. 1803 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Capt. Charles A. Bell

6 DATE OF BIRTH (month, day, and year): June 26 1840

7 AGE: Years 86 Months 6 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Joseph Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Groomman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ellen C. Lamm (Address) 1803 N. Calvert St.

15 Filed May 9 1927. 19 C. HAMPSON JONES, Registrar. Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1927 to May 8th, 1927

that I last saw her alive on May 8th, 1927

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Infantile Neuralgia (Tic-douloureux) Old age

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary): Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry, M. D.

5-9, 1927 (Address) 414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 12 1927
20 UNDERTAKER	ADDRESS
John O. Metcalf & Son	1911 E. Oliver Place

TION is very important. See instructions on back of certificates. EXACT STATEMENT OF OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22057

CERTIFICATE OF DEATH.

132 ✓ E 22057

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Kimpel

(a) RESIDENCE NO. 2540 E. Fayette St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Kimpel

6 DATE OF BIRTH (month, day, and year): June 26 1871

7 AGE: Years 55 Months 10 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry Shoemaker

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Spangler

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: August Kimpel

(Address): 2540 E. Fayette St

15 Filed: 1927 C. HAMILTON JONES, M. D. Registrar

By: R.K.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 7, 1927, that I last saw h.e.r. alive on May 7, 1927, and that death occurred, on the date stated above, at 5-50 A.m.

The CAUSE OF DEATH* was as follows:

Pyelohydronephrosis

Renal calculus

Nephritis acute

(duration) yrs. 1 mos. 4 ds. ?

CONTRIBUTORY (Secondary) Myocardial failure & pulmonary edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 6.

Was there an autopsy? No.

What lest confirmed diagnosis? Clinical, history & operat

(Signed) C. Hyman, M. D.

, 19 (Address) S. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial 5/11/1927

20 UNDERTAKER: Gu. Hubert & Son ADDRESS 2503 Edmondson Ave

This certificate, properly filled out, must be in the hands of the undertaker before any body can be buried or removed. Last statement of OCCUPATION is very important. See instructions on back of certificate.

9

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22058

CERTIFICATE OF DEATH.

90 ✓ E 22058

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1533 N Eden St., 9-17 Ward)

2-FULL NAME Mary Jennings

(a) RESIDENCE NO. 1533 N Eden St St. 9 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Jennings

6 DATE OF BIRTH (month, day, and year) 2/22/1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	V	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) County Galway Ireland

PARENTS

10 NAME OF FATHER Richard Holland

11 BIRTHPLACE OF FATHER (city or town):

(State or country) County Galway Ireland

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant Son

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1927, to May 7, 1927, that I last saw her alive on May 6, 1927, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

~~Hypostatic Congestion~~

Hypostatic Congestion

Myocardial Degeneration

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. P. Franklin, M. D.

, 19 (Address) 4 East E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: May 10 1927

20 UNDERTAKER: Rita Wiedefeld & Grumm — ADDRESS

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

E 22059

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 1254

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] Ward)

2-FULL NAME Eugene Boss

(a) RESIDENCE NO. 2100 Ethnig St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hostler

(b) General nature of industry, business, or establishment in which employed (or employer): 0 2 4

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N.C

12 MAIDEN NAME OF MOTHER Mary Boss

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 [illegible] 19 C. HARRISON JONES, M. D. Registrar

1927 340

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1927

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1927, to May 5, 1927

that I last saw him alive on May 4, 1927

and that death occurred, on the date stated above, at 5.55 A.M.

The CAUSE OF DEATH* was as follows:

Bacteraemia Generalized

Etiology not known.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

May 6 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Health. MAY 5 1927

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 22060

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22060

CERTIFICATE OF DEATH

REGISTERED NO. 37 4-25

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Deas

(a) RESIDENCE NO. 520 W. Saratoga st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Richard Deas

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Marie Tucker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 5-9-1927 C. HUDSON JONES, M. D. Registrar

Per 1341

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 21 19 27 to May 6 19 27

that I last saw him alive on May 6 19 27

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gallens, M. D.

5-6-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Department Health MAY 9 192

Bureau of Vital Statistics

very important. See instructions on back of certificates.

9

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22061

CERTIFICATE OF DEATH

E 22061

1-PLACE OF DEATH Maryland Gen. Hosp. 11-25 162

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dula

(a) RESIDENCE NO. Emerald Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6, 1927.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Gen Hosp Baltimore Md.

PARENTS

10 NAME OF FATHER James C Dula

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Mamie Page.

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

14 Informant Mrs Mamie Dula (Address) Emerald Md

15 Filed 1927 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to May 6, 1927, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

1. Aspiration
2. Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Jones Jr M. D.

, 19 (Address) Emerald Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL MAY 9 19

20 UNDERTAKER ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22062

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22062

CERTIFICATE OF DEATH

69

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 15-62

City of BALTIMORE: (No. 33rd St & Calvert St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Lois Schaub

(a) RESIDENCE NO. 3704 Copley Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 22, 1924

7 AGE: Years 2 Months 11 Days 16 14

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER Wm Otto Schaub

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER Betty Brown

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Hospital Records

(Address)

Filed 1927 C. HAMPSON JONES, M. D. Registrar

By RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 8, 1927,

that I last saw her alive on May 8, 1927,

and that death occurred, on the date stated above, at 11 05 P. m.

The CAUSE OF DEATH* was as follows:

acidosis

and

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) myocardial collapse

7 hours

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin & lab methods

(Signed) Frank R Smith, Jr., M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: 5/10 1927

20 UNDERTAKER: Henry W. Rogers & Son — ADDRESS: 805 N. Calvert

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Information must be given, so that it may be properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22063

CERTIFICATE OF DEATH

90 E 22063

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Keyser -

(a) RESIDENCE NO. 400 W. Camden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 69 - Months - Days - IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: John M Keyser

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unk.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mr. E. Lester Keyser (Nephew)

(Address) 201 Cole Ave Raspeberg

15 [illegible] 1927 C. HARRISON JONES, M.D. Registrar

Per A.F.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1927 to May 7, 1927

that I last saw him alive on May 7, 1927

and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows: Bilateral Osteomyelitis, Chronic Myocarditis, Cellulitis of Left Leg -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inguinal Bubonocele

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3-28-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. Blueyer, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: May 10, 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1110 Fleet St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22064 E 22064

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E. Woodland Ave WARD 27-56

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry E. Hellmeyer

(a) RESIDENCE NO. 24 E. Woodland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Hellmeyer

6 DATE OF BIRTH (month, day, and year) June 24. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	76	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ~~Rudolf~~ Christian Hellmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pooth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Schroeder

(Address) 24 E. Woodland

15 Filed 5-7 1927 C. HAMPSON JONES, M. D. Registrar

Per R C H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25 1927 to May 7 1927.

that I last saw him alive on May 6 1927.

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Endocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Chronic Bronchitis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Emory, M. D.

(Address) 5106 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL May 10 1927

20 UNDERTAKER Mr. Mrs. J. H. Tuffle & Son — ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22065 (186)

CERTIFICATE OF DEATH.

E 22065

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPT. St., 9-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Yowell

(a) RESIDENCE NO. 819-F St. Sparrows Point st md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov-16-1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Waverly Yowell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Harrison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Record

(Address) JOHNS HOPKINS HOSPT

15 Filed ..... 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 May 8-

17 I HEREBY CERTIFY, That I attended deceased from May 6, 19 27, to May 8-, 19 27, that I last saw h[illegible] alive on May 8-, 19 27, and that death occurred, on the date stated above, at 12 M. a m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease; subacute bacterial endocarditis, atyp. verrucous

(duration) 11 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Shealy, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial May 10 1927

20 UNDERTAKER Lilly-Zeiler ADDRESS 403 E. Monument St

1927 RRH

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22066

101-601

E 22066

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 N. Washington St., 6-9 Ward)

2-FULL NAME Frank Henry Schlhorst

(a) RESIDENCE NO. 222 N Washington St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colour

5 ~~Single~~, Married, ~~Widowed, or Divorced. (write the word)~~: married

5a If married, ~~widowed, or divorced~~ HUSBAND of (~~or WIFE of~~): Mathilda Schlhorst

6 DATE OF BIRTH (month, day, and year): Dec 28-1865

7 AGE: Years 58 | Months 4 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer): Automobiles

(c) Name of employer: Motor Controller Co

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Lewis Schlhorst

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothy Hansen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Mathilda Schlhorst

(Address): 222 N Washington

15 Filed ..... 19..... Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6 19 27, to May 7 19 27, that I last saw h[illegible] alive on May 7 19 27, and that death occurred, on the date stated above, at 10-20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward [illegible] M. D.

6/7, 19 27 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial May 10 1927

20 UNDERTAKER: Lilly + Zeiler

ADDRESS: 4008 Wash Blvd

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

22067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 22067

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 S. Schroeder St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fischer

(a) RESIDENCE NO. 30 S. Schroeder St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Fischer

6 DATE OF BIRTH (month, day, and year) January 20th 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Fischer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Annie Fischer

(Address) 30 S. Schroeder St

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 6th. 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/20/26 to 5/6/27

that I last saw him alive on 5/6/27

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic

the 1st Night.

(duration) unkn yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) Gerard J. Fenn, M. D.

5/7, 1927 (Address) 910 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial May 19 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Eutaw St

E

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22068 — E 22068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Stmr Express Pier No. 16 Light St. Wharf

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Gerdes.

(a) RESIDENCE NO. 1704 E. Fort Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic on

(b) General nature of industry, business, or establishment in which employed (or employer): Stmr. Express.

(c) Name of employer: Tolchester Steamboat Co.

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant: Albert Mielke.

(Address) 1468 Andre St.

15 1927 C. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 4 ribs right side, hemorrhage shock. Accidently crushed between paddle wheel and side of steamer.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt, M. D.

(Coroner)

5/9, 1927 (Address) 1027 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Brooklyn. Date of Burial: May 10/27

20 UNDERTAKER: Wm. Cook ADDRESS: 502 E North

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22069

E 22069

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Mc Culloh ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Grace Ward

(a) RESIDENCE NO. 2313 Mc Culloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chairwoman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: United Railways

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Emma Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Louise Burns

(Address) 2313 Mc Culloh

15 Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to May 7, 1927.

that I last saw h alive on May 7, 1927

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Aug 8 1927 (Address) 1209 Arrestown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 8/10/1927

20 UNDERTAKER: Wm. Geo. R. Holland — ADDRESS: 1698 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22070

CERTIFICATE OF DEATH.

90

E 22070

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1929 McCulloh St. (or Ward) 14-20

2-FULL NAME Fillian Birnes

(a) RESIDENCE NO. 1929 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Birnes

6 DATE OF BIRTH (month, day, and year) Sept 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Judge Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Caroline

12 MAIDEN NAME OF MOTHER Mary J ~~Holland~~

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant Eulene Jones

(Address) 1929 McCulloh St

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1925, to May 7, 1927, that I last saw h.. alive on May 7, 1927, and that death occurred, on the date stated above, at 1301 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J Trey, M. D.

5/9, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.L. Auburn Date of Burial 5/10/1927

20 UNDERTAKER Wm. Geo. H. Holland ADDRESS 1631 Druid Hill

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22071 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22071

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—NO. 112 E Lanvale ST. 17-55 WARD)

2-FULL NAME Edward M Lorz

(a) RESIDENCE NO. 112 E Glenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Lorz

6 DATE OF BIRTH (month, day, and year) May 8th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Am. Coal Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Lorz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Goetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas Lorz

(Address) 112 E Lanvale

15 MAY 11 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to May 8, 1927, that I last saw h.... alive on May 8, 1927, and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolus Sudden

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) Herbert Earle, M. D.

, 19 (Address) 2107 Gwynns Falls Pkwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 11 1927
20 UNDERTAKER	ADDRESS
E Schlosman Sons	Gwynns Falls Pkwy

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22072

101-001

E 22072

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 126 W Hamburg St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beverly Brooks

(a) RESIDENCE NO. 126 W Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Brooks

6 DATE OF BIRTH (month, day, and year): apr – 15 – 1875

7 AGE: Years 52 Months – Days 22 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Days Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Whitewashing Co

(c) Name of employer: Self –

9 BIRTHPLACE (city or town): A. Arundel Co

(State or country): Mary Land.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) .....

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) .....

14 Informant: Ruth Reese

(Address) 126 W Hamburg

15 Filed 10 1927 C. HAMILTON JONES, M. D. Registrar

Per K.M.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8/1927

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1927, to 5/8, 1927.

that I last saw h[illegible] alive on 5/8, 1927.

and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Dan Drumheller, M. D.

5/9, 1927 (Address) 1224 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Furnace Branch

Date of Burial: May [illegible] 19

20 UNDERTAKER: V. L. Bloom & Son

ADDRESS: [illegible]

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22073

101-001

CERTIFICATE OF DEATH.

E 22073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Mosher St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Dillingham

(a) RESIDENCE NO. 209 Mosher ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Six yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Florence Dillingham

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	62	3	24 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None retired

(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Chester Pa.

PARENTS

10 NAME OF FATHER Webb B. Dillingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Chester Pa.

12 MAIDEN NAME OF MOTHER Alice Ebbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Pa.

14 Informant Mary D. Dillingham (Address) 615 Chestnut St. Ridley Pk. Pa.

15 Filed May 10 1927 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

17

I HEREBY CERTIFY, That I attended deceased from May 2 1927 to May 8 1927

that I last saw him alive on May 8 1927 at 9.20 P. m.

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia —

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No — Date of

Was there an autopsy? No —

What tests confirmed diagnosis?

(Signed) Chevertsmith, M. D.

May 9 1927 (Address) 1327 Park Ave — Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa.	May 13th 1927
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co.	McCulloh & Richards

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22074 — **CERTIFICATE OF DEATH.** — **E 22074**

161-001

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chester

(a) RESIDENCE NO._____ St._____ Ward_____ Towson Run Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-5-27

7 AGE	Years	Months	Days	IF LESS than 1 day G. hrs. or.....min.
0	0	0	0	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0d

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER William Henry Chester

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Beulah E. Eisenman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto, Md

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

1335 RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-5-27

17

I HEREBY CERTIFY, That I attended deceased from 5-5, 1927, to 5-5, 1927, that I last saw h.e.v. alive on 5-5, 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Weinraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

Very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL

MAY 5 1927

Cor.—12-9-25—A Co.—200 Eds. Edwin R. Stringer

HEALTH DEPARTME[illegible] BALTIMORE

E 22075 CERTIFICATE OF DEATH E 22075

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. Little Ridg Lexington & St. Paul St., 4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ed. R. Stringer

(a) RESIDENCE NO. Glyndon md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Blanche Stringer

6 DATE OF BIRTH (month, day, and year) Jan 6 1878

7 AGE: Years 49 Months 4 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER William R Stringer

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Robertson F Kenafax

14 Informant Taylor Stringer

(Address) 204 Jettings ave Bethesda

15 Filed MAY 10 1927 C. HANSEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by revolver shot wound in brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. C. Tilley (Coroner) M. D.

May 9, 1927 (Address) 1037 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery Date of Burial: May 10 1927

20 UNDERTAKER: J F Elaine & Sons Reisterstown Md ADDRESS

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22076

CERTIFICATE OF DEATH.

112

E 22076

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 334 S. Mount St. St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Elizabeth Roden

(a) RESIDENCE NO. 334 S. Mount St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 7, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Singer Sewing Machine Co.

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Roden

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Revell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Bernard J. Roden

(Address) 334 S. Mount St.

15 Filed....., 19 C. HARRISON JONES, M. D.

MAY 10 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

May 9 1927 (Address) Curtis Bay, Balto. Maryland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: May 11 1927

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Balto St.

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22077

E 22077

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1129 h. Mount St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Rebecca Perkins

(a) RESIDENCE NO. 1129 Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: George S. Perkins

6 DATE OF BIRTH (month, day, and year): Jan 15. 1908

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	19	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town): Frederick Co

(State or country): Md.

PARENTS

10 NAME OF FATHER: Jacob Holland

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Frederick Co Md.

12 MAIDEN NAME OF MOTHER: Ella Diggs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: George S. Perkins

(Address): 1129 Mount St

MAY 10 1927

Filed HARRY S. JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15 1927, to May 7, 1927,

that I last saw h[illegible] alive on May 7, 1927

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 517 Calhoun St.

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) E. Wellman, M. D.

5/8, 1927 (Address) 1928 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

Date of Burial: May 10 1927

20 UNDERTAKER: Thomas E. Kelso

ADDRESS: [illegible] Pennsylvania Ave

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sterquel

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22078

CERTIFICATE OF DEATH.

90 **E 22078**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 N. Gay ST. 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Sterquel

(a) RESIDENCE NO. 1233 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Sterquel Nov 8th 1865

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Bauerlipp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: James Sterquel (Address) 1233 N. Gay St.

15 Filed MAY 10 1927 19 C. HAMPSON JONES, M. D. Registrar Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 8 - 1927

17 I HEREBY CERTIFY, That I attended deceased from JAN 7 - 1921 . 19 ..., to MAY 8 - 1927 . 19 .

that I last saw her alive on MAY 6 - 1927 . 19 ,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

acute Dilatation of Heart

(duration) yrs. / mos 5 ds.

CONTRIBUTORY (Secondary): Myocarditis Fibrosa

(duration) 10 yrs. / mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Decker, M. D.

(Address) 928 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. DATE OF BURIAL: May 10th 1927

20 UNDERTAKER: Leo G. Leach ADDRESS: 1723 Pratt St

Live

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22079

CERTIFICATE OF DEATH

E 22079

1-PLACE OF DEATH

REGISTERED NO. 47

City of BALTIMORE: (No. 2015 Lafayette Ave St. West Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) —

2-FULL NAME Mrs Rose Brink

(a) RESIDENCE NO. 2015 W. Lafayette Ave St. — Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 1 ds. How long in U. S. if of foreign birth? 1 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Mr John H. Brink

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 58 Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town): Annapolis Md.

(State or country)

PARENTS

10 NAME OF FATHER: Nelson Basil

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country): Unknown.

14 Informant: Geo. E. Shannon

(Address): 700 Fulton Ave

Filed MAY 10 1927, 19 ..... H. LAWSON JONES, M. D.

Per R.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1927, to May 10, 1927, that I last saw h. ✓ alive on May 9, 1927, and that death occurred, on the date stated above, at 7.10 ✓ m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ✓ yrs. 2 mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. ✓ mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George E. Shannon, M. D.

May 10 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md. — Date of Burial: May 12 1927

20 UNDERTAKER: Taylor & Sons — ADDRESS: Annapolis Md.

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22080

CERTIFICATE OF DEATH

E 22080

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 801 W 35 St.) (Ward) LA 3-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ardenia Crawford

(a) RESIDENCE NO. 801 W 35 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Joseph E Crawford

6 DATE OF BIRTH (month, day, and year): May 12 1870

7 AGE — Years: 56 Months: 11 Days: 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): E Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joseph E Crawford (Address) 801 W 35 St

15 Filed MAY 10 1927 HARRIS JONES M. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1926, to May 8, 1927.

That I last saw h[illegible] alive on May 8, 1927.

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary [illegible]

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Myocardial [illegible]

(duration) 5 yrs. mos da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 5/6/27

Was there an autopsy? No Where? Private in Hampden County

What test confirmed diagnosis? Phys. Exam.

(Signed) John W Graham M. D.

. 19 (Address) 820 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

Date of Burial: May 11 1927

20 UNDERTAKER: Ehrenwerth Son

ADDRESS: 361 Chestnut

Very important. See instructions on back of certificates. Unauthorized statement of OCCUPATION is

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22081

CERTIFICATE OF DEATH.

E 22081

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3639 Roland Ave St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman E. Heathcote

(Residence in Baltimore: No. 3639 Roland Ave St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Feb 21 1892
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
48 yrs. 2 mos. 17 ds.	....hrs. or....mdn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Pa.

PARENTS.

10-NAME OF FATHER. Louis E. Heathcote

11-BIRTHPLACE OF FATHER, (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Emma Deane

13-BIRTHPLACE OF MOTHER, (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Heathcote

(Address) 3639 Roland Ave

15-
Filed MAY 10 1927 192.....
C. HARRY JONES, M.
Per ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 8 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said... (Inquest, autopsy or Inquiry.) ...find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular disease of Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

5/9 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	May 11, 19

20-UNDERTAKER. Chenoweth Son

ADDRESS 3615 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22082

CERTIFICATE OF DEATH.

38

E 22082

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Loud Ball Hosp.

City of BALTIMORE: (No. 1713 S. Light St. 27-30 Ward)

2-FULL NAME Robt Walter Merker

(a) RESIDENCE NO. 515 Shaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 25, 1927

7 AGE: Years | Months 1 | Days 15

IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md

PARENTS

10 NAME OF FATHER Oscar Merker

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Martha Seeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) Light St

15 Filed ... 1927 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927, to May 10 1927, that I last saw h... alive on May 10 1927, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Miller, M. D.

May 10, 1927 (Address) Loud Ball Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — Date of Burial: May 11 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22083 — CERTIFICATE OF DEATH. — 100 201 E 22083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 912 N Wolfe ST. 7-13 (WARD)

2-FULL NAME Lorine Giles

(a) RESIDENCE NO. 912 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Upshur Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Penn

14 Informant Mary Giles (mother)

(Address) 912 N Wolfe St

Filed MAY 10 1927 HARRISON JONES M. D. Registrar

For —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

I HEREBY CERTIFY, That I attended deceased from May 1, 1927. to May 8, 1927.

that I last saw her alive on May 8, 1927.

and that death occurred, on the date stated above at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. L. Young, M. D.

5/9, 1927 (Address) 4724 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany Cemetery — DATE OF BURIAL May 11 1927

20 UNDERTAKER Jos. T. H. Rochester — ADDRESS 1413 Jefferson St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22084

CERTIFICATE OF DEATH.

11-24 129

E 22084

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 342 Dolphin St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Grace Booker

(a) Residence No... 342 Dolphin St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Booker

6-DATE OF BIRTH (month, day and year) month unknown 1847

7-AGE 80 yrs. 8 mos. ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va.
(State or Country),

PARENTS.

10-NAME OF FATHER, Allie Sweat

11-BIRTHPLACE OF FATHER (city or town)..... Va.
(State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) Washington Co.
(State or Country),

14- (Informant) Wm. H. Booker

(Address) 2115 Druid Hill Ave

15- Filed OCT 10 1927 C. HAMPSON JONES, Registrar. RKK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1926 to May 7 1927

that I last saw h.. alive on May 6 1927

and that death occurred, on the date stated above, at 5,45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Littlebrains M. D.

, 19 (Address) 817 Montpelier

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

16-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cem.

DATE OF BURIAL. 5/10 27

17-UNDERTAKER. Samuel T. Kinsley

ADDRESS 515 N. Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22085 1-PLACE OF DEATH — REGISTERED NO. E 22085

City of BALTIMORE: (No. 1303 Argyle Ave St. 17-24 Ward 202)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Medley

(a) RESIDENCE NO. 1303 Argyle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17, 1914

7 AGE: Years 10 11 | Months 7 8 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Irvin Medley

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Lena Canton

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Courtney Driscoll

(Address) 1303 Argyle Ave.

15 Filed MAY 10 1927, 19 C. HARRISON JONES, M. D. Registrar

Per R R C

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 9 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

(duration) few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) pieces of apple lodged in throat (duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

19 27 (Address) 2802 Edmondson Ave

May 10,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem | Date of Burial 5/10 1927

20 UNDERTAKER Samuel T. Hemsley | ADDRESS 1778 W. Baltimore

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 22086

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22086

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas White

(a) RESIDENCE NO. 10 N Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE: Years 26 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Cornelius White

11 BIRTHPLACE OF FATHER (City or town) Maryland. (State or country)

12 MAIDEN NAME OF MOTHER Edith

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Friends (Address) Balto City Hospitals

15 Filed 5/12/27 C. HAMPSON JONES, M. D. Per R.R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 19 27 to May 8, 19 27 that I last saw ~~him~~ alive on May 8, 19 27 and that death occurred, on the date stated above, at 9:4 ~~P~~ M.

The CAUSE OF DEATH* was as follows:

Lymphoid Sarc. Generalized Epithelioid Cell Sarc. Generalized Metastatic

(duration) Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 6, 1927

Was there an autopsy? No

What test confirmed diagnosis? Graham

(Signed) W. Bluegrel M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Date of Burial: May 12 1927

20 UNDERTAKER: C. L. Brown & Son ADDRESS: 108 Monroe

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22087

CERTIFICATE OF DEATH

4+ E 22087

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma R. Whitely

(a) RESIDENCE NO. 241 West Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If ~~married, widowed,~~ or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 2, 1858

7 AGE — Years: 68 Months: 11 Days: 9 7 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balt.

(State or country): Md.

PARENTS

10 NAME OF FATHER Benj Whitely

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER Elizabeth Stone

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balt. Md.

14 Informant Mrs Chas. Baker

(Address) Balt. Md.

15 Filed ... 19 ... C. HARRIS ... Registrar

Per

0 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 9, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to May 9, 1927,

that I last saw h alive on May 9 1927,

and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma – biliary tract & general metastasis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Not Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings, X-ray

(Signed) J Bernaglia, M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — Date of Burial: May 11' 1927

20 UNDERTAKER: Geary Heuleins Sons Co — ADDRESS: Forest and Mosher Sts

Very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Dr Hornstein 733 Aug. St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22088

CERTIFICATE OF DEATH

129

E 22088

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 432 N. High St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Byrnes

(a) RESIDENCE NO. 432 N. High St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Byrnes

6 DATE OF BIRTH (month, day, and year): Dec 11 1885

7 AGE: Years 41 Months 1 Days 28 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Joseph Herring

9 BIRTHPLACE (city or town): Galt

(State or country): Md

PARENTS

10 NAME OF FATHER: Michael Byrnes

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Alice Smith

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Catherine E. Byrnes

(Address) 1027 Fredonia Ave

15 Filed MAY 10 1927, 19 C. [illegible] (Registrar)

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/19, 1927, to 5/8, 1927

that I last saw him alive on 5/8, 1927

and that death occurred, on the date stated above, at 5:50 A. M.

The CAUSE OF DEATH* was as follows:

Ch Nephritis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? —

if not at place of death?

Did an operation precede death? No Data of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

5/9, 1927 (Address) 733 Aug. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary

Date of Burial: May 12 1927

20 UNDERTAKER: J. H. Cook

ADDRESS: 602 North

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22089

CERTIFICATE OF DEATH.

101-00

E 22089

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel E. Horlacher

(a) RESIDENCE NO. 121 Scott St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Horlacher

6 DATE OF BIRTH (month, day, and year) Sept 26/1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Horlacher

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Helen Winterbottom

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant Sadie Horlacher

(Address) 900 W. Balto St

MAY 10 1927 C. HERBERT JONES, M. D.

Per RMK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-probably Lobar

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. S. Culler M. D.

(Coroner)

5/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Date of Burial May 10 1927

20 UNDERTAKER W. M. Cook ADDRESS 512 E. North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22090

CERTIFICATE OF DEATH.

90 E 22090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 N Carlton St. 18th Ward)

2-FULL NAME Cinderella Larkin

(a) RESIDENCE NO. 103 N Carlton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year):

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Easton Md

(State or country)

PARENTS

10 NAME OF FATHER: Zachi Roberts

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Cinderella Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Mary Denton

(Address): 112 N Carlton

Filed MAY 10 1927 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 25 1927, to May 7, 1927, that I last saw h..... alive on May 7, 1927 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date

Was there an autopsy?

What test confirmed diagnosis?

Signed May 7 1927 J. Howard Jones, M. D.

(Address) 931 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem Date of Burial May 10 1927

20 UNDERTAKER: Leonard Whalen ADDRESS 9 Myrtle Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22091

CERTIFICATE OF DEATH.

90

E 22091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 W. Lexington ST. 20-27 WARD)

2-FULL NAME Catherine E. Stump

(a) RESIDENCE NO. 1813 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E Stump

6 DATE OF BIRTH (month, day, and year): April 4, 1865

7 AGE

Years	Months	Days	If LESS than 1 day, ... brs. or ... min.
62	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Patrick Collard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Cauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Mr John E Stump 1813 W Lexington St

15 Filed MAY 10 1927, 19... C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8/ 1927

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to May 8, 1927, that I last saw her alive on May 8, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Donnell M. D.

5/10, 1927 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 5/11/ 1927

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 901 Hollins St

Cor.—1-12-23—M&T—100 Bks.

E 22092 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22092

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 302 Hoffman ST. 11-24 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Gale

(a) RESIDENCE NO. 302 Hoffman St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 29th 26

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	11.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) City

(State or country)

10 NAME OF FATHER Pollie Gale

11 BIRTHPLACE OF FATHER (city or town) City

(State or country)

12 MAIDEN NAME OF MOTHER Sophie Emory

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

Informant Sadie Gale

(Address) 302 Hoffman St

Filed [illegible] 192 [illegible] CHESTER JONES, M. D.

Per [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

(Signed) J. T. Hennessy, M. D.

(Coroner)

May 10, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion DATE OF BURIAL May 11 1927

20 UNDERTAKER Thomas E Wagstaff ADDRESS 1844 McCulloh

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22093

CERTIFICATE OF DEATH

E 22093

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hobby Norton

(a) RESIDENCE NO. 501 W Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1854

7 AGE: Years 73 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant George L Voigt

(Address) 501 W Baltimore St

Filed 10 1927, 19 C. HAMILTON JONES, Registrar

By RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 5-7-27

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1927, to 5-7-, 1927,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5 08 m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis - Chronic Myocarditis - Chronic Interstitial Nephritis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

Regist (duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial: May 11 1927

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22094

CERTIFICATE OF DEATH.

129

E 22094

REGISTERED NO.

1-PLACE OF DEATH Removed dead at

City of BALTIMORE: (No. Balto City Hospital St. 3-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hobbs

(a) RESIDENCE NO. 1001 Salisbury Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 60 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 4-27, 19

4242 RPB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(duration) yrs. mos. ds.

(Signed) James H Fenton M. D.
(Coroner)

4/30 1927 (Address) 7002 Chancellor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health.

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22095

CERTIFICATE OF DEATH.

198

E 22095

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Mutrie

(a) RESIDENCE NO. 211 N. Central Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Police Dept.

(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 25/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lung Abcess &sepsis- Stab Wound of Chest. Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Beam, M. D.
(Coroner)

5/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

1911 CRH

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22096

CERTIFICATE OF DEATH.

1927 E 22096

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Beatty

(a) RESIDENCE NO. 1608 E. Fayette St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laboner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Police Dept.

(Address)

5, 1927, 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis- Pistol Shot Wound

Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

5/9/27 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND MAY 10 1927

Spec.–7-17-26—A Co.—200 Bks.

E 22097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 22097

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1214 Jefferson St. 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Long

(a) RESIDENCE NO. 1214 Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-9-27

7 AGE Years Months Days IF LESS than 1 day hrs. or 5 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Long

11 BIRTHPLACE OF FATHER (City or town) N C

(State or country)

12 MAIDEN NAME OF MOTHER Pinkie Jones

13 BIRTHPLACE OF MOTHER (city or town) N C

(State or country)

14 Informant Pinkie Jones Long

(Address) 1214 Jefferson

15 Filed 19 Registrar

1316

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-9 27

17 I HEREBY CERTIFY, That I attended deceased from 5-9, 1927, to 5-9, 1927

that I last saw h[illegible] alive on 5-9 1927

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Fetal causes

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

5-9, 1927 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

202 6 12 E 22098

CERTIFICATE OF DEATH.

100-001 E 22098

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (Nonns HOPKINS HOSPI St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Green

(a) RESIDENCE NO. E L Crem Cilten Ave Horse Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3-28-27

7 AGE: Years: 1 mos | Months: 1 | Days: | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Thelma Green

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

PARENTS

14 Informant Friends

(Address) JOHNS HOPKINS HOSPI

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

U 1927 1348 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 1927, to 5/8, 1927, that I last saw h.... alive on 5/8, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pneumonia (hyaline)

(duration) ...yrs. ...mos. 1 wk.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. P. Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health. MAY 19 1927

Spec.—1-12-23—M&T—500 Bks.

E 22099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 Pool

E 22099

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N. Wolfe ST., 7-2 WARD)

2-FULL NAME Baby Davis

(a) RESIDENCE NO. 821 N. Wolfe ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8, 27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Lobe Blount

11 BIRTHPLACE OF FATHER (city or town) Detroit
(State or country) Mich.

12 MAIDEN NAME OF MOTHER Anna Davis

13 BIRTHPLACE OF MOTHER (city or town) Chester
(State or country) S.C.

14 Informant .....
(Address) .....

15 1927 C. HAMPSON JONES, M. D. Registrar

Pay 3.00 RRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 8, 1927, that I last saw h— alive on May 8, 1927, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) W. I. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Blks.

E 22100 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22100

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 S. Clinton ST. 76-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph L. Haupt

(a) RESIDENCE NO. 914 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freda Haupt.

6 DATE OF BIRTH (month, day, and year) Jan 24 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant (Address) Freda Haupt 914 S. Clinton St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to May 8, 1927, that I last saw him alive on May 8, 1927 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Terminal Ascites

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry O. Athey, M. D.

5/9, 1927 (Address) 2564 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL May 11 1927

20 UNDERTAKER George W. Zinkler

ADDRESS 1739 E. Eager St

Spec.—1-10-21—M&T—3500 Bks.

E 22101 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22101

CERTIFICATE OF DEATH.

11-607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 Markland Ave. WARD) 27-46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Hughes

(a) RESIDENCE NO. 408 Markland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Hughes

6 DATE OF BIRTH (month, day, and year): Jan 21. 1858

7 AGE: Years 69 Months 3 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Sarah E. Hughes

(Address) 408 Markland Ave.

15 1927 . 19 . C. HAMPSON JONES, M. D.

Per RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5 - 9 - 1927

17

I HEREBY CERTIFY, That I attended deceased from May- 5, 1927. to May 9, 1927.

that I last saw h— alive on May 8, 1927.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hal S Hoes, M. D.

5-9, 1927 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: May 11 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Fremont Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22102

CERTIFICATE OF DEATH.

90 E 22102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 Woodbra ave ST. 27-41 WARD)
(Gardnerville)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Briscoe

(a) RESIDENCE NO. 50 Woodbra ave {Gardnerville} ST., WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Briscoe

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W. Foy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Mrs Velmur Bennett
(Address) R. 50 Woodbra ave Gardnerville

15 Filed ..... 19 ..... Registrar

0 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 27

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927 to May 8, 1927 that I last saw h[illegible] alive on May 7, 1927 and that death occurred, on the date stated above, at 2 A [illegible] m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Cardiac Arthma 7 ds.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 1 ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Fred Dargent M. D.

May 9, 1927 (Address) 700 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 11 1927

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N Broadway

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22103

CERTIFICATE OF DEATH.

31

E 22103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1726 Johnson ST. 24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Clark

(a) RESIDENCE NO. 1726 Johnson ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura L. Clark

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 57; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Berwin Md.

PARENTS

10 NAME OF FATHER: Joseph Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Raymond L. Clark 1732 Hanover St.

15 May 10 1927 RRB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to May 8, 1927, that I last saw h~~e~~ alive on May 8, 1927, and that death occurred, on the date stated above, at 11-30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Duration yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

Duration yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Campbell M. D.

May 9, 1927 (Address) 1624 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 5/11 1927

20 UNDERTAKER: Mary M. Medefield

ADDRESS: 201 E. 20th St

E 22104

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22104

CERTIFICATE OF DEATH.

Registered No. C 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2930 Huntingdon Ave St. 17-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Andrew J. Justis

(Residence in Baltimore: No. 2930 Huntingdon Ave St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Mar. 17 1869
(Month) (Day) (Year)

7-AGE. 58 yrs. 1 mos. 21 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foreman Car Shop
(b) General nature of industry, business, or establishment in which employed (or employer). United Elec Ry

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Benj. T. Justis

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Mary A Childress

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben. T. Justis

(Address) 2930 Huntingdon Ave

15- Filed 1927 192 C. HAMPSON JONES, M. D. Per RCH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. 5 8 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry H. Weinstein M. D.
(Coroner.)

5/10 1927 (Address) 3672 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. May 11 1927

20-UNDERTAKER. A S Marshall ADDRESS 3539 Lafayette Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22105

CERTIFICATE OF DEATH.

100-00

E 22105

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 4-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Baum

(a) RESIDENCE NO. Orphanage-St.Vincent DePaul Society Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) 192?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Hospital Records

(Address)

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192? May 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis (Pneumonic)
Bronchopneumonia

(Autopst at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Gittings M. D.
(Coroner)

5/10/27 (Address) 506 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL George A. Fear Sons Date of Burial 5/11 1927

20 UNDERTAKER Thos. J. Kelly Sons ADDRESS 1318 Eutaw St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22106

CERTIFICATE OF DEATH

1927 E 22106

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 304 Laurence St. 14-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Skinner

(a) RESIDENCE NO. 304 Laurence St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Robert Skinner

6 DATE OF BIRTH (month, day, and year): April-11-1870

7 AGE: Years 57 Months Days 26

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co.

(State or country)

PARENTS

10 NAME OF FATHER Robt Briscoe

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Brown

13 BIRTHPLACE OF MOTHER (City or town) Md

(State or country)

14 Informant: Mrs Mary Briscoe

(Address) 304 Laurence St

Filed MAY 10 1927 C. HARRISON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to May 7, 1927

that I last saw her alive on May 1, 1927

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Lucas Tracy, M. D.

May 9, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — Date of Burial: 5/11 1927

20 UNDERTAKER: Samuel H Busby & Co — ADDRESS: 1928

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22107

CERTIFICATE OF DEATH.

88 E 22107

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 218 Eutaw St. 23-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza DeCoursey

(a) Residence No. 218 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of married

6-DATE OF BIRTH (month, day and year) June 1866

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Wm Alsop

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Harriet Estep

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Miss Eliza DeCoursey

(Address) 218 Eutaw St

Filed May 11 1927 CHARLTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9 1927

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1927 to May 9, 1927

that I last saw h alive on May 9, 1927

and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis 7 mos

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. Crook M. D.

, 19 (Address) 65 W Lan St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Zion — DATE OF BURIAL, May 11 1927

20-UNDERTAKER, John W. Trader — ADDRESS, 1012 Druid Hill

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22108

CERTIFICATE OF DEATH.

E 22108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 21-29 (WARD) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmedes

(a) RESIDENCE NO. 731 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schmedes

6 DATE OF BIRTH (month, day, and year) June 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mary Schmedes (Address) 731 W. Hamburg St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1927, to 5-9, 1927, that I last saw him alive on 5-9, 1927, and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis acute exacerbation; latter fatal lasted 9 days.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic condition of prostate (duration) 4 yrs. mos. ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Physical findings

What test confirmed diagnosis?

(Signed) W P C McDavid M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md. DATE OF BURIAL 5-12 1927

20 UNDERTAKER Bernard C Harle ADDRESS 1000 S Pkwy

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22109

CERTIFICATE OF DEATH.

188-003

E 22109

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin C Starkes

(a) RESIDENCE NO. 4306 Parrish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy E Starkes

6 DATE OF BIRTH (month, day, and year) 11-3-1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage Collector

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unk

12 MAIDEN NAME OF MOTHER Blue Yard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Dorothy E Starkes

(Address) 4618 W Cheltenham Ave

15 Filed 1 1 1927 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Contusion of abdomen Fracture of pelvis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured skull

(duration) yrs. mos. ds.

(Signed) Harold C Starkes, M. D. (Coroner)

, 19 27 (Address) 832 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	May 12th 1927

20 UNDERTAKER	ADDRESS
George Schilling & Sons	1136 E Monument St

Spec.—12-9-25—A Co.—200 Bks.

E 22110

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

E 22110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-68 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Barken

(a) RESIDENCE NO. 1540 Morland Ave. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Barkin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Berman

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Barth —

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Louis Barken

(Address) 1540 Morland ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-9-27

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1926, to 5-9, 1927, that I last saw her alive on 5-9, 1927, and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma Lt kidney
Generalized metastasis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max Rosenfeld, M. D.

5/10 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mehren Rosedale 5/11 1927

20 UNDERTAKER ADDRESS

Jos. Levis 1409 E Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22111 57 E 22111

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tillie Bressler

(a) RESIDENCE NO. 6 N. Eden St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Bressler

6 DATE OF BIRTH (month, day, and year): About 1875

7 AGE: Years 52 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Isaac Bressler

(Address) 6 N. Eden St.

15 Filed ..... 19 .....

Registrar

4 1 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

March 19 27 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel | Date of Burial 5/11 1927

20 UNDERTAKER: Jack Levin | ADDRESS 1439 Bank

Spec.—1-R 23—M&T—500 Bks.

B 22112

HEALTH DEPARTMENT—CITY OF BALTIMORE

7E 22112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No.) Rayner and Dukeland (ST.) 1776 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Henderson

(a) RESIDENCE NO. 729 Fremont Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~weeks~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Danbush, Ga

PARENTS

10 NAME OF FATHER Isaac Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie Lesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levy

(Address) 1431 E Baltimore

15 Filed MAY 11 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/25, 1927, to 5/10, 1927

that I last saw him alive on 5/10, 1927

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic syphilis

Unknown but at least (duration) 1 yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & A.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 5/11 1927

20 UNDERTAKER Jack Levy

ADDRESS 1439 E Baltimore

Spec.-7-17-26—A Co.—200 Bks.

E 22113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 22113

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert Sts. Ward) 26-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Howard Parker (Alberta)

(a) RESIDENCE NO. Bucks Lane, West Arlington Ward
(Usual place of abode) Balt., Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Mr. Howard Parker

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1879.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	48	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt.,
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Poe
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Maryland.
12 MAIDEN NAME OF MOTHER Mary Hanson
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Husband
(Address)

Filed MAY 11 1927 C. HARRISON JONES, M. D. Registrar
Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 10, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to May 10, 1927,
that I last saw her alive on May 10, 1927,
and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
? (duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Multiple furunculosis
? (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings and
(Signed) W. S. Gardner, M. D.
19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mays Cem. Balto Co.	May 13, 1927
UNDERTAKER Chenoweth Son	ADDRESS 3615 Chestnut Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22114

CERTIFICATE OF DEATH

E 22114

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3850 Falls Road St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M. Taylor

(a) RESIDENCE NO. 3850 Falls Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Taylor

6 DATE OF BIRTH (month, day, and year) Aug 18, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER John J. Stuss

11 BIRTHPLACE OF FATHER (City or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary A Wise

13 BIRTHPLACE OF MOTHER (city or town) md

(State or country)

14 Informant John W Taylor

(Address) 3850 Falls Road

15 Filed MAY 11 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to May 9, 1927

that I last saw h alive on May 9, 1927

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

Gall Stones

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo Koldewey M. D.

May 11 19 27 (Address) 1900 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park	May 12, 19 27
20 UNDERTAKER	ADDRESS
Chenowith Son	3615 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

E 22115

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 958 Harlendale St. 14 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Faith Byrd

(a) RESIDENCE NO. 958 Harlendale WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1927

7 AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Smith Byrd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Hodge.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Smith Byrd (Address) 958 Harlendale

15 Filed May 11 1927 C. HARRISON JONES, M. D. Registrar

Fair

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 10, 1927, that I last saw h alive on May 10, 1927, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Traumatic Injury

by instrumental Delivery

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Concussion Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

5-10-27 (Address) 2017 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary DATE OF BURIAL May 11 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Oakland

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22116

REGISTERED NO. 1627 E 22116

1-PLACE OF DEATH

City of BALTIMORE: (No. 3600 Eversley St. 40-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leo. Gary

(a) RESIDENCE NO. 3600 Eversley St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8, 1927

7 AGE — Years — Months 2 Days. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James E. Gary

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Georgia Sauk

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant James E. Gary

(Address) 3600 Eversley St.

15 Filed C. HAMILTON JONES, M. D. Registrar

MAY 11 1927 Per R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 10, 1927, that I last saw h[illegible] alive on May 10, 1927, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

, 19 (Address) 5511 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: May 11, 1927

20 UNDERTAKER: Margaret S. Flynn ADDRESS 1422 Eutaw St.

Spec.–7-17-26—A Co.—200 Bks.

Dr Horn, 2808 N Calvert St

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22117

CERTIFICATE OF DEATH

E 22117

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2727 Overlea Ave St., 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Volz

(a) RESIDENCE NO. 2727 Overlea Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Volz.

6 DATE OF BIRTH (month, day, and year): Mar 14, 1865

7 AGE: Years 62 Months 1 Days 20 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John A. Koerting

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward H. Volz

(Address) 2727 Overlea Ave

15 Filed MAY 11 1927 19

Per

THOMSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1927, to May 9d, 1927, that I last saw h Er alive on May 9d, 1927, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted 2727 Overlea Ave if not at place of death? c

Did an operation precede death? c Date of c

Was there an autopsy? No

What test confirmed diagnosis? Clin. Course & C

(Signed) August Horn, M. D.

May 10 1927 (Address) 2808 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery — Date of Burial: May 12 19

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

Dr Stone - 2808 N Calvert St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22118

CERTIFICATE OF DEATH

90 E 22118

1-PLACE OF DEATH

REGISTERED NO. 27-44

City of BALTIMORE: (No. 39 Ailsa Ave St. ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Pertsch

(a) RESIDENCE NO. 39 Ailsa Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Pertsch

6 DATE OF BIRTH (month, day, and year): Feb. 1, 1862

7 AGE: Years 65 Months 3 Days 5 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Pertsch

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mehnert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Anna Pertsch 39 Ailsa Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1927, to May 9th, 1927, that I last saw him alive on May 9th, 1927, and that death occurred, on the data stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation + Arterial Stenosis

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation + Pressure + C

(Signed) August Horn, M. D.

(Address) March 10 1927 2808 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: March 11 1927

20 UNDERTAKER: J. H. Cook — ADDRESS: 507 Chatham

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22119

CERTIFICATE OF DEATH.

90 E 22119

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital N. Charles St. 16-66 St. Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy N. Stallings

(a) RESIDENCE NO. 2704 Baker St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth 20 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Stallings

6 DATE OF BIRTH (month, day, and year): Mar 31 1883

7 AGE: Years 44 | Months 1 | Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Floor Scraper

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (City or town) Calvert Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Stallings

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Hester F. —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Eva Stallings

(Address) 2704 Baker St

15 Filed MAY 7 1927, 19__ at __ M. C. H. Registrar

For _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/27, 19__

17 I HEREBY CERTIFY, That I attended deceased from 4/27/27, 19__, to 5/7/27, 19__, that I last saw h__ alive on 5/7/27, 19__, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Endocarditis Chronic,

(duration) __ yrs. __ mos. __ ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) 1 yrs. __ mos. __ ds.

18 Where was disease contracted? Home

If not at place of death, Hosp.

Did an operation precede death? __ Date of __ May 4 27

Was there an autopsy? __

What test confirmed diagnosis? __

(Signed) W. E. Hague, M. D.

, 19__ (Address) 1711 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. Date of Burial 5/11 1927

20 UNDERTAKER: Philip Henry ADDRESS 2016 Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22120

E 22120

1-PLACE OF DEATH

REGISTERED NO. 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

2-FULL NAME Raymond G. Wolf.

(a) RESIDENCE NO. 418 E. Gittings St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 5 mo. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) November 24, 1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Wolf.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Eva Guyton.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.

(State or country)

14 Informant Eva Wolf. (mother)

(Address) 418 Gittings St.

Filed MAY 11 1927 H. LAWSON JONES, M. D. Registrar

Ref. R.C.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a row boat.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Bernhardt M. D. (Coroner)

5/10 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Off of Cahil's Machine shop foot of Webster st. May 9, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesley M. Date of Burial May 13 1927

20 UNDERTAKER Chas. L. Stevens ADDRESS 1st Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22121 E 22121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 27-31

City of BALTIMORE: (No.) 821 Leddenhall (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Johnny Hunt

(a) Residence No. 821 Leddenhall St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Col | 5-Single, Married, Widowed, or Divorced, (Write the word.) Mard

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Hattie Hunt-

6-DATE OF BIRTH (month, day and year) 1868

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer). — 040

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Joshua Hunt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Hattie Hunt

(Address) 821 Leddenhall

15- Filed MAY 11 1927 C. HAMDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9. 1927

17- I HEREBY CERTIFY, That I attended deceased from Apr 22 1927 to May 8 1927 that I last saw h— alive on May 8 1927 and that death occurred, on the date stated above, at 8:45 A.M. The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No Special Exam.

What tests confirmed diagnosis? P.O. Garland Simpson M. D.

(Signed) May 11, 1927 (Address) 1534 - 20 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Ashley Amity	May 12. 1927
20-UNDERTAKER	ADDRESS
Robert A. Williams	1515 W. Eldorado St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

22122

CERTIFICATE OF DEATH

E 22122

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 338 N. Bruce St., 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Pitts

(a) RESIDENCE NO. 338 N. Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 - 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	1	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Jas Rowlings

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Pitts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Sallie Pitts

(Address) 338 - N. Bruce

Filed MAY 11 1927 C. H. [illegible] JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 19 27, to May 10, 19 27, that I last saw h[illegible] alive on May 9, 19 27, and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 16[illegible] Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 11 - 1927

20 UNDERTAKER Daniel Easton ADDRESS 944 Baine

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22123

CERTIFICATE OF DEATH

74001

E 22123

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1047 Guilford Ave. St.) (11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Hadewig

(a) RESIDENCE NO. 1047 Guilford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of the late Dietrich Hadewig

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE: Years 80 Months — Days —

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Wm. Duffy

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country) .....

14 Informant Mr. Otto Hadewig

(Address) 1931 Belair Road

15 Filed ..... 19 ..... C. H. WILLIAMSON JONES, M. D.

MAY 11 1927 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9 1927 to May 9th 1927

that I last saw h~~e~~r alive on May 9th 1927

and that death occurred, on the date stated above, at 11.0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 1 hr. ..... ds.

CONTRIBUTORY (Secondary) Coma

(duration) ..... yrs. ..... mos. ½ hour

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. H. Williamson Jones M. D.

May 10. 1927 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial May 12 1927

20 UNDERTAKER Henry Hoeck & Son — ADDRESS 1201 E Eager St

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 22124

E-22124 CERTIFICATE OF DEATH

REGISTERED NO. .....

City of BALTIMORE: (No. 2420 Aisquith St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina R. Seitz

(a) RESIDENCE NO. 2420 Aisquith St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 10 mos. 1 ds. How long in U. S. If of foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late William G. Seitz.

6 DATE OF BIRTH (month, day, and year): July 9 1868

7 AGE: Years 58 Months 10 Days 1 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John N. Gessner

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Frances Steiger

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Wm. Peter Gessner

(Address) 12 E. Virginia Ave

15 Filed MAY 11 1927 19 HARRY JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-5 1927 to 5-8 1927 that I last saw h... alive on 5-8 1927 and that death occurred on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows: Ulcer of Pylorus

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) J. Hurdis Fisher, M. D.

19 27 (Address) 1000 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: May 13 1927

20 UNDERTAKER: Dorsey Storck Son — ADDRESS: 1301 E Eager St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22125

CERTIFICATE OF DEATH

E 22125

REGISTERED NO. 8-13

1-PLACE OF DEATH

City of BALTIMORE: (No. 1235 N. Broadway St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha L. Dietz

(a) RESIDENCE NO. 1235 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Dietz.

6 DATE OF BIRTH (month, day, and year) Not date

7 AGE About Years 48 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife - H

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Edward J. Trosford

11 BIRTHPLACE OF FATHER (City or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Anna Millicent

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Mr. Mannon Farrow

(Address) 1235 N. Broadway

15 Filed JUL 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mch 3, 1927 to May 10, 1927

that I last saw h alive on May 10 1927

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

2 (duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY General carcinomatosis -

(Secondary)

Toxaemia - (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) George Abner Gardner, M. D.

5/10, 1927 (Address) 1517 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: May 13 1927

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS 1301 E. Eager

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22126

CERTIFICATE OF DEATH.

129 E 22126

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Millinan St., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah A. Anderson

(a) RESIDENCE No. 1623 Millenan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of — or) WIFE of George T. Anderson

6 DATE OF BIRTH (month, day, and year) Feb 9 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Ayres.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER Hester Bowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Carrie Jackson

(Address) 1623 Millenan

15 Filed MAY 11 1927 Per C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-20-, 1927, to 5-9-, 1927, that I last saw h[illegible] alive on 5-8-, 1927, and that death occurred, on the date stated above, at 1205 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) Not known. yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) Not known. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H. Leargier, M. D.

5-10- 1927 (Address) 614 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 11 1927
20 UNDERTAKER	ADDRESS
Wm. M. Cross & Co	1700 Madison

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 25 34 22127

90 ✓

CERTIFICATE OF DEATH.

REGISTERED NO. L 22127

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St. _____ Ward) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Judah

(a) RESIDENCE NO. 3715 Harford Rd St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Judah

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER — Putzel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MAY 11 1927 Per L.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 10, 1927, that I last saw her alive on May 10, 1927, and that death occurred, on the date stated above, at 2 3/4 9 m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

Mitral obstruction & insufficiency

Auricular fibrillation

(duration) 19 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary infarct

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Autopsy

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Thebey, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthew's — Date of Burial May 12, 1927

20 UNDERTAKER Richard F. Curley. ADDRESS 2016 E North ave

Cor.—12-9-25—A Co.—200 Bks.

E 22128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 22128

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 E. Fort Ave. 23-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas O. King.

(a) RESIDENCE NO. 30 E. Fort Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXX Ida E. King.

6 DATE OF BIRTH (month, day, and year) November 1, 1869.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town)

(State or country) Montgomery Co, Md.

PARENTS

10 NAME OF FATHER John D. King.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Lucinda Watkins.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Montgomery Co. Md.

14 Informant Howard T. King. (son)

(Address) 30 E. Fort Ave.

15 Filed MAY 1 1927 S. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Weinhardt M. D. (Coroner)

5/10 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Damuskus Cem Monts Co 5/12 1927

20 UNDERTAKER ADDRESS

J. F. McCully 130 E Fort

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22129

CERTIFICATE OF DEATH.

4 E 22129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 832 N. Washington St., 7 WARD)

2-FULL NAME Catherine W Bassady

(a) RESIDENCE No. 832 N. Washington St., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE: Female White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13 1892

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sale Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John K. Bassady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Mackin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John K. Bassady

(Address) 832 N. Washington St.

15 Filed MAY 11 1927 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to May 9, 1927.

that I last saw h.. alive on May 9, 1927.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Sore Throat

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) Frank J. Ayd M. D.

May 11, 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 12 1927

20 UNDERTAKER: Wm. J. Schaeffer — ADDRESS: 1816 Monument

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22130
PLACE OF DEATH

REGISTERED NO. E 22130

City of BALTIMORE: (No. 1010 S. Bouldin St. St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teofil Dombroski.

(a) RESIDENCE NO. 1010 S. Bouldin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Dombroski.

6 DATE OF BIRTH (month, day, and year) Feb. 5- 1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Adam Dombroski.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Rosa Sulchinska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Frank Zelenski

(Address) 1010 S. Bouldin St.

C. HERMAN JONES, M. D.

15 Filed JUN 1 1927, 19

Per R.H., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926, to May 10, 1927, that I last saw h.im alive on May 10, 1927, and that death occurred, on the date stated above, at 8:10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchо-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & Symptoms

(Signed) John V. Negrotti, M. D.

, 19 (Address) 735 S. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial May 12 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22131 ~~2250~~

CERTIFICATE OF DEATH.

38 E 22131

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 16 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Larkins

(a) RESIDENCE NO. 1519 E. Lanvale St. City Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 12-22-26

7 AGE: Years: — Months: 4 mos. Days: 18 IF LESS than I day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Bd

(c) Name of employer

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER John Larkins

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Clara Worford

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed: C. HAMPSON JONES, M. D.

1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 19, 1927, to May 10, 1927, that I last saw him alive on May 10, 1927, and that death occurred, on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Lues c Nephritis

(duration) ___ yrs. 4 mos. ___ ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ___ yrs. ___ mos. 2 ds.

18 Where was disease contracted? If not at place of death? Baltimore

Did an operation precede death? No. Date of_____

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann + Kline Kondax

(Signed) J. C. Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: May 12 1927

20 UNDERTAKER: Jno. M. Johnson — ADDRESS 1234 Ething St.

Spec.—12-9-25—A Co.—200 Bks.

22132

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 9 E 22132

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Arlington Av Sts. 16 23 Ward)

2-FULL NAME Emma L. Jackson

(a) RESIDENCE NO. 920 Arlington Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hawley Jackson

6 DATE OF BIRTH (month, day, and year): Dec 17 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): W. Va

PARENTS

10 NAME OF FATHER: Henry Washington

11 BIRTHPLACE OF FATHER (city or town):

(State or country): W. Va

12 MAIDEN NAME OF MOTHER: Louisa Jackson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): W. Va

14 Informant: Marcus Lewis

(Address): 1939 Druid Hill Ave

15 Filed 1927 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 10, 1927, to May 8, 1927, that I last saw h.. alive on May 8, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos. Dys ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. McRae, M. D.

5/10. 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: N.D. Auburn Cemetery — Date of Burial: May 12 1927

20 UNDERTAKER: J.N.M. Johnson — ADDRESS 1234 Eutaw St.

Spec.—12-9-25—A Co.—300 Bks.

E 22133

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22133

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospls

City of BALTIMORE: (No. Balto Md St. 14-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A Smith

(a) RESIDENCE NO. 1833 W Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (Write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Steven Smith

6 DATE OF BIRTH (month, day, and year) Unknown. 1850

7 AGE 77 Years 76 Months — Days — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ...

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Unknown

14 Informant Balto City Hospls

(Address) Balto Md

15 Filed ... 19 ... Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 5-10-27

17 I HEREBY CERTIFY, That I attended deceased from 4-10 1927 to 5-10, 1927 that I last saw h alive on 5-10, 1927 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry F. Downes, M. D.

5/11/1927 (Address) Baltimore City Hospitals

*Since the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial 5/13/1927

20 UNDERTAKER John J Howard & Son ADDRESS 901 Hollins

Spec.–7-17-26—A Co.—200 Bks.

E 22134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22134

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3541 Caton Ave 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertram Joseph Borman

(a) RESIDENCE NO. 3541 Caton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	1	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Borman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wolker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Elizabeth Wolker

(Address) 3541 Caton Ave

15 [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1926, to May 10, 1927, that I last saw him alive on May 10, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Carcoma of Kidney (Right)

(duration) yrs. 6 mos — da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Dec 4. 1926

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic finding

(Signed) Sidney H. Stabeth M. D.

1927 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co — Date of Burial 5-12 1927

20 UNDERTAKER E & B Hark 115 E West St — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

E 22135 297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 91-002 E 22135

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (Johns Hopkins Hospital 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Nicodemmus

(a) RESIDENCE NO. Everett - Pa St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10-2-56

7 AGE: Years 70 | Months 7 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Pa.

PARENTS

10 NAME OF FATHER Herbert Nicodemmus

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Pa

12 MAIDEN NAME OF MOTHER Katie Eash

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Pa

14 Informant Records

(Address) Johns Hopkins Hospital

15 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-16-27

17

I HEREBY CERTIFY, That I attended deceased from 5-7, 1927, to 5-11, 1927

that I last saw h.. alive on 5-11, 1927

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy with Obstruction

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 5-11-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Everett Pa — Date of Burial: 5/11/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

Spec- 12-23-21—E.B.R.S.—400 Bks.

E 22136

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22136

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1126 Myrtle ave St., 17th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mc Nally

(a) Residence No. 1126 Myrtle ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W-

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late John H Mc Nally

6-DATE OF BIRTH (month, day and year) 3/25/1852

7-AGE. 75 yrs. 1 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Pat Kinn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) John P. Mc Nally

(Address) 1126 Myrtle Ave

15- Filed 1927 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9 1927

17- I HEREBY CERTIFY, That I attended deceased from Jany 4, 1927 to May 9 1927

that I last saw h.. alive on May 9 1927

and that death occurred, on the date stated above, at 5 15 p m.

The CAUSE OF DEATH* was as follows: 5 days

Acute Endocarditis

(Obstruction) Gall stone

Chr Myocarditis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Claude M. D.

May 9, 1927 (Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL. 5-12, 1927

20-UNDERTAKER, H. Brauning & Son

ADDRESS 617 N Schroeder St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22137 E 22137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Green Sts., 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Orton Hagar

(a) RESIDENCE NO. Boston, Mass St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie M. Hagar

6 DATE OF BIRTH (month, day, and year) October 20, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Developer

(b) General nature of industry, business, or establishment in which employed (or employer) 616

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver Hagar

11 BIRTHPLACE OF FATHER (city or town)

(State or country) United States

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Elsie M. Hagar

(Address) Boston, Mass.

15 1927 C. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally run over by auto truck, Laurel Md.

Fractured Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Albert O. Hagar M. D.

(Coroner)

5/11 19 27 Address 332 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston, Mass. Date of Burial May 12, 1927

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 N. Calvert St.

Spec.—1-12-23—M&T—500 Bks.

E 22138 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital.

CITY OF BALTIMORE: (No.) Caroline & Oliver (ST.) 9-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Shanahan.

(a) RESIDENCE NO. Glen Arn. Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7. 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glen Arn, Md.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Shanahan.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ann Livingston.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary E Shanahan.
(Address) Glen Arn Md

Filed 1927 C. HARRISON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to May 11th, 1927, that I last saw her alive on May 11th, 1927, and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH* was as follows:

Otitis media - Bilateral.
Intestinal toxemia -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Monroe, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John Cemetery Govans

DATE OF BURIAL May 12 1927

20 UNDERTAKER Clarence E. Arthur

ADDRESS Fork Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22139

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22139

CERTIFICATE OF DEATH.

69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Edmondson Ave) (WARD) 6-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ruhl Moore

(a) RESIDENCE. NO. 2400 Edmondson Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1927

7 AGE — Years: — Months: 4 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Laurence Edward Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Minnie Ruth Ruhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Laurence Moore

(Address) 2400 Edmondson ave.

15 Filed 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1927 to May 10, 1927.

that I last saw h[er] alive on May 10, 1927.

and that death occurred, on the date stated above, at 930 A. m.

The CAUSE OF DEATH* was as follows:

Hemmorhagica Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemophilia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Macke M.D.

, 19 (Address) 2303 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 5/12/27

20 UNDERTAKER: Geo Lemmbuch & Son

ADDRESS: 225 N. Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

E 22140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+90 E 22140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 9 Ward)

2-FULL NAME Mrs Helen Matthai

(a) RESIDENCE NO. 1220 Frost Rd; Sparrow's Point Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Matthai

6 DATE OF BIRTH (month, day, and year) October 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	29	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Miles Durkin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant John E. Matthai

(Address) Sparrows Point, Md.

15 1927 Rec'd C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 8 1927, to May 11, 1927, that I last saw h(e) alive on May 11 1927, and that death occurred, on the date stated above, at 1 55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 12 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 10, 1927

Was there an autopsy? no Suspension of uterus

What test confirmed diagnosis?

(Signed) Harold H. Norris M. D.

May 1, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Date of Burial May 15, 1927

20 UNDERTAKER E. Leroy Stiffler

ADDRESS 125 E. North Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 22141

CERTIFICATE OF DEATH.

38 E 22141

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Univ. Hospital St. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Kelly

(a) RESIDENCE NO. 211 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- dt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single.

5a If married, widowed, or divorced (husband of or wife of) ------

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	9	2 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Joseph M. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie L. Fay

13 BIRTHPLACE OF MOTHER (city or town) Cumberland (State or country) Maryland

14 Informant Miss Elizabeth A. Fay

(Address) 211 W. Franklin Street

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/25, 1927, to 5/10, 1927, that I last saw him alive on 5/10, 1927, and that death occurred, on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Neuro Syphilis Duret. 12-15 yrs.

Malaria " 1 yr.

Septicemia " 1 wk.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home + at Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) E. R. Miller, M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/12, 1927
20 UNDERTAKER	ADDRESS
Henry U. Dyers & Son	805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

E 22142 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 15-63

CITY OF BALTIMORE: (No. Lombard & Green St., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander P Brooks Jr

(a) RESIDENCE NO. 4105 Baltimore St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Alexander P. Brooks Sr

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Southern

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Alexander P. Brooks Jr (Address) 4105 Baltimore St

15 Filed [illegible], 1927. C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-24-27, 19 , to 5-11-, 1927, that I last saw him alive on May 11th, 1927, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumour

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home 5 yrs ago

Did an operation precede death? yes Date of 4/25/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W B Hendrix, M. D.

5/11, 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria, Va — DATE OF BURIAL May 12 1927

20 UNDERTAKER Wm J. Dickson & Sons — ADDRESS Norfolk Va

Inez Gantt

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22143 HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 22143

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Dolphin Av St.) 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Inez Gantt

(a) RESIDENCE. No. 515 Dolphin Av ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm R Gantt

6 DATE OF BIRTH (month, day, and year): 11-4-1900

7 AGE — Years: 26 — Months: 5 6 — Days: 4 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo W. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Wm R. Gantt (Address) 515 W. Dolphin Av

15 Filed 1 2 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to May 10, 1927, that I last saw her alive on May 9, 1927, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

duration yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) C. B. Flora M. D.

May 11 1927 (Address) 712 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: May 13 27

20 UNDERTAKER: John H Toadvine — ADDRESS 1028 Hanover

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22144
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 22144
REGISTERED NO.

City of BALTIMORE: (No. Md Gen Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha M Rittenour.

(a) RESIDENCE NO. Chase Md St. Ward Inst Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Robert Rittenour

6 DATE OF BIRTH (month, day, and year) May 22nd 1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Enoch Rittenour

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mollie Clem

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Robert Rittenour
(Address) Chase Md

15 Filed MAY 12 1927 19 Per C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 hr

May 11 27 (Signed) G E Slade M. D.
(Coroner)

(Address) 143 N Main

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19 PLACE OF BURIAL, CREMATION OR REMOVAL Strasburg Va — Date of Burial May 12 1927

20 UNDERTAKER George Schulting & Sons — ADDRESS 1126 E Monument St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22145 — 51 — E 22145

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 E. 32nd. ST., G-46 WARD)

2-FULL NAME John. Frederick. Naumaw

(a) RESIDENCE NO. 1907 E 32nd. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 10-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work attended School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER J. Frederick Naumaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie E. Gamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. J. Frederick Naumaw
(Address) 1907 E. 32nd St.

15 Filed MAY 12 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1927

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to May 11, 1927.

that I last saw him alive on May 11 1927

and that death occurred, on the date stated above, at 10 55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Inflamatory Rheumatism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O Carey M. D

(Address) 1623 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 14th 1927

20 UNDERTAKER Henry Storck Son — ADDRESS 801 E Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22146 49 ✓ E 22146

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 104 E. 25th St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Deale

(a) RESIDENCE NO. 104 E. 25th. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Deale

6 DATE OF BIRTH (month, day, and year) July 27 1863

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	63	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Horatio M. Vail

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Anna Medcalf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant John S. Deale

(Address) 104 E. 25th St

15 Filed MAY 12 1927 19 HAMPDEN-WOVES, MD. Registrar K M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 - 1925, to May 10 1927,

that I last saw h[illegible] alive on May 10 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) 1½ yrs. mos ds.

CONTRIBUTORY Metastatic Carcinoma of Pelvis

(Secondary)

with obstruction (duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? Yes Date of Oct 5-1926

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Examination

(Signed) Robert A Littlefield, M. D.

5/11, 1927 (Address) 7117 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loraine Cemy.	May 13. 1927
20 UNDERTAKER John C. Mitchell & Sons	ADDRESS 1900 Eutaw Pl

DAY 12 1927

See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 22147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-502 E 22147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2907 E. Calvert ST. 17-50 WARD)

2-FULL NAME Emily Kate Ulrig

(a) RESIDENCE NO. 2907 E Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

(If non-resident give city or town and State) England

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis N. Ulrig

6 DATE OF BIRTH (month, day, and year): March 9 1853

7 AGE — Years: 74 — Months: 2 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Henry Trenlinton

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ely Orme

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Lewis N. Ulrig (Address) 2907 E. Calvert St.

15 Filed APR 12 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 30 1927, to May 10th 1927.

that I last saw her alive on May 10 1927

and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis due to Thrombosis of Cerebral Vessels

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary): Hypertension Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eastler, M. D.

, 19 (Address) 607 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemy — DATE OF BURIAL: May 13 1927

20 UNDERTAKER: Chas O. Mitchell & Sons — ADDRESS: 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

3133 Lauchlan Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22148

CERTIFICATE OF DEATH.

90

E 22148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 139 Wilkens ST. (or) WARD) 2069

2-FULL NAME Hermann E. Kluge

(a) RESIDENCE NO. 139 Wilkens ST., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A. Kluge

6 DATE OF BIRTH (month, day, and year) July 24, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 088

(b) General nature of industry, business, or establishment in which employed (or employer) Self Boss

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frances A. Kluge

(Address) 139 Wilkens St

15 Filed MAY 12 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 , 1927 , to May 9 , 1927 , that I last saw h[illegible] alive on May 9 , 1927 , and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elmer B Lemmon M. D.

May 11, 1927 (Address) 718 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 12 1927

20 UNDERTAKER H. B. Wappert

ADDRESS 1850 W. Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22149

CERTIFICATE OF DEATH.

5-28 | 29 | E 22149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 S. Payson ST. 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora Heinz

(a) RESIDENCE NO. 202 S. Payson ST., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Heinz

6 DATE OF BIRTH (month, day, and year) May 2nd 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	84	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernest Kirschke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leopoldine Cahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernestine Kirschke (Address) 202 S Payson St

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19 1927, to May 10 1927, that I last saw her alive on May 10 1927, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Hellen Heinz M. D.

5/12 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 13 1927

20 UNDERTAKER F B Shippit ADDRESS 1552 W Baltimore

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 22150

CERTIFICATE OF DEATH

E 22150

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 826 S. Luzerne Ave St., V3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Simmond

(a) RESIDENCE NO. 826 S. Luzerne Ave / Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 10th 1927

7 AGE Years Months Days 1½ IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Gilbert Simmond

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Martha Callenberger

13 BIRTHPLACE OF MOTHER (city or town): Balto. Md.

(State or country)

14 Informant: Gilbert Simmond

(Address) 826 S. Luzerne Ave

15 Filed MAY 12 1927 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10 1927 to May 11 1927 that I last saw h[er] alive on May 11 1927 and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Reavey M. D.

19 (Address) 814 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: May 12th 1927

20 UNDERTAKER: Lilly + Geiler — ADDRESS: 1030 Wolfe St

Spec.–7-17-26—A Co.—200 Bks.

Amette

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22151

CERTIFICATE OF DEATH

34 E 22151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Amette

(a) RESIDENCE NO. 204 So 3rd St (Street) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 10th 1862

7 AGE: Years 65 Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Amette

11 BIRTHPLACE OF FATHER (City or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Reilly

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

14 Informant: Mrs Paul Hartman Daughter

(Address) 527 S. East Ave.

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

MAY 12 1927

R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-14-27, to 5-10-27,

that I last saw him alive on 5-10-27, 19 ,

and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Disease

Dilatation of Heart

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Paralysis last

Lung trouble (duration) yrs. mos. 4 wks

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Edwin M. Robertson, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: May 12 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22152

CERTIFICATE OF DEATH.

90 E 22152

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wilson

(a) RESIDENCE NO. 1352 Carroll St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Sam Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane –

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1927

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 9, 1927, that I last saw him alive on May 9, 1927, and that death occurred, on the date stated above, at 12 00 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypostatic lung and pneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. D. Goo, per Lamb, M. D.

May 11 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease [redacted] from Violent Causes, state (1) Means and Nature of Injury [redacted] Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Zion Cemetery May 12 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22153

CERTIFICATE OF DEATH.

139 E 22153

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1337 W. 42 ST. 13-57 WARD)

2-FULL NAME Irene A. Baker

(a) RESIDENCE NO. 1337 W. 42 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Lewis E Baker

6 DATE OF BIRTH (month, day, and year): May 25, 1893

7 AGE — Years: 34 — Months: 1 — Days: 15 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Louis N. Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Hannah Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Mr Lewis E. Baker 1339 W. Lanvale St.

15 Filed 1927 By ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to May 10, 1927, that I last saw h[illegible] alive on May 10, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Injection Examination Psychosis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Hysterectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical & Mental Exam.

(Signed) ..... M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 13 27

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

E 22154

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22154

CERTIFICATE OF DEATH.

5-61 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3001 Windfield Ave ST. (Ward)

2-FULL NAME David Goldberg

(a) RESIDENCE No. 3001 Windfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Goldberg

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Esther Goldberg

(Address) 3001 Windfield Ave

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10* 1927, to the May 11, 1927, that I last saw him alive on May 11, 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cardiac asthma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation Oedema of lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Goldman, M. D.

May 11, 1927 (Address) 3201 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nursery Rd DATE OF BURIAL 5/12 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22155 E 22155

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver (St.) 27-43 (Ward) Gardiner

2-FULL NAME Mrs Caroline Delahay

(a) RESIDENCE NO. 300 Walnut Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Mark. R. Delahay

6 DATE OF BIRTH (month, day, and year) Nov. 8. 1885

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs. or ..... min.
	41	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Frederick. Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Anna Klingelhoefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mark R. Delahay 300 Walnut Ave Balto.

15 Filed MAY 21 1927 C. HAMPSON JONES, M. D., Registrar. Post KK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March. 27. 1927. to May 10. 1927.

that I last saw her alive on May 10. 1927.

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis -
Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Frank R. Dieffenbach, M. D.

(Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 12 1927

20 UNDERTAKER D. Schloman Son

ADDRESS 1039 Hanover St

Spec.–7-17-26—A Co.—200 Bks.

4218 / Dr Gordon Montebello Terrace

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22156

CERTIFICATE OF DEATH

1946

E 22156

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4514 Wetzel St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Mabel West

(a) RESIDENCE NO. 4514 Wetzel St. Ward

(Usual place of abode) Life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-12-884

7 AGE Years 43 Months 4 Days 28 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Business

(b) General nature of industry, business, or establishment in which employed (or employer) Devoin Candy

(c) Name of employer Company

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Columbus West

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Kirby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Ida West

(Address) 4514 Wetzel St.

15 Filed MAY 12 1927

C. HAMPSON JONES, M. D. Registrar

Page

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1926 to May 10 1927.

that I last saw her alive on May 9 1927.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of Dec 13 1926

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) L. L. Gordy, M. D.

5-11 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

Date of Burial 11/14 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mont

Key important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Smith 4706 Harford Rd

74-001

REGISTERED E 22157

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 Carswell St., 9th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L. Remmer

(a) RESIDENCE NO. 1602 Carswell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 11 1859

7 AGE: Years 68 Months 3 Days 29 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): D & C

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Frank Remmer

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Alice ?

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Catherine Wilhelm

(Address) 1602 Carswell St

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

By RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7 1927 to May 10 1927 that I last saw h[illegible] alive on May 10 1927 and that death occurred, on the data stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Hemiplegia, Arteriosclerosis, Cerebral Hemorrhage

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold Brunk M. D.

5/11 1927 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

Date of Burial May 12 1927

UNDERTAKER W. H. Cook

ADDRESS 5021 York

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

202750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3233 E 22158

E 22158 REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Finney

(a) RESIDENCE NO. 1810 Carrollton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred T. Finney

6 DATE OF BIRTH (month, day, and year): Oct 8-1898

7 AGE: Years 28 | Months 7 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER — Williams

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER Jane Coleman

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 12 1927 G. HAMPSON JONES, M. D. Registrar

Per E.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to May 6, 1927, that I last saw her alive on May 6, 1927, and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 2 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Bulogical

(Signed) Milton Sandler, M. D.

5-10 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — Date of Burial: May 12 1927

20 UNDERTAKER: Sam'l. M. Chase & Son — ADDRESS: 1400 Mosher

Spec.—1-12-23—M&T—500 Bks.

Evelyn Ridgely

E 22159 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH M Hospital

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 27-54 (WARD) 401-0

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister E. Ridgely

(a) RESIDENCE NO. Mt Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. 10 ds. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3rd 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	24	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Convent Record (Address)

15 Filed MAY 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to May 12, 1927, that last saw h.. alive on May 12, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D'Arcole M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Convent Mt Washington — DATE OF BURIAL May 13 1927

20 UNDERTAKER Henry Kirkwood's Sons Co — ADDRESS McCulloh & Richmond

Cor.—12-9-25—A Co.—200 Bks.

Euge Mack.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22160

100-001

CERTIFICATE OF DEATH.

E 22160

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 835 W Lanvale St. Ward)

2-FULL NAME Euge mack (Pratt adopted)

(a) RESIDENCE NO. 835 W Lanvale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 4/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) Balt.

(State or country)

PARENTS

10 NAME OF FATHER Eugene Mack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Agnes Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant Ella Mack

(Address) 835 W Lanvale St.

MAY 12 1927 Filed HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Daniel E Hanlon M. D.

(Coroner)

, 19 27 (Address) 332 S Pitt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial 7/13 1927

20 UNDERTAKER Daniel Hanlon — ADDRESS Highland

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22161

CERTIFICATE OF DEATH.

17-2-90 E 22161

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 W Hoffman St.; WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Randall

(Residence in Baltimore: No. 614 Hoffman St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Col

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (Write the word.) Widow

6-DATE OF BIRTH, ..., (Month) (Day) 1856 (Year)

7-AGE, 71 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Smith

(Address) 523 Lambert St

15-

Filed ....., 191.....

C. HAMPSON JONES, M. D.

Per ..... Registrar.

4/2 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5-11-27 (Month) (Day) , 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-8- 1927, to 5-11- 1927, that I saw h[illegible] alive on 5-11-27 191, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Chron Gastritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 1 yrs. mos. ds.

(Signed) J R Bork M. D.

....., 191... (Address) 618 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 4/4/27

20-UNDERTAKER David Cantor

ADDRESS 914 Park

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22162

CERTIFICATE OF DEATH.

E 22162

90

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 644 Greendlow St. 7-24 Ward)

2-FULL NAME Rachel Conyer

(a) RESIDENCE NO. 644 Greendlow St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
(or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	IF LESS than 1 dny.....hrs. or.....min.
	63	—	~	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Dont Know
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Catherine Denny
(Address) 1318 N Greendale

15 Filed 12 1927 C. HAMPSON JONES, M. D. Registrar
Per R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1926, to May 10, 1927,
that I last saw h. alive on May 10, 1927,
and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular
Heart Disease
(duration) 2 yrs. 4 mos. ds.
CONTRIBUTORY Umbilical Hernia
(Secondary)
(duration) 3 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. Wallace Tyler, M. D.
11, 1927 (Address) 928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial 5/13 1927

20 UNDERTAKER Jamie Euston — ADDRESS 916 Pa Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22163 — 1-PLACE OF DEATH

167-001

E 22163 — REGISTERED NO.

City of BALTIMORE: (No. 10 N. Calhoun St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard L. Dandridge

(a) RESIDENCE NO. 10 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown about 40 yrs old

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about 40	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer —

9 BIRTHPLACE (city or town) ...

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ...

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Unknown

14 Informant Copy of Army Discharge

(Address) U.S. Veterans Bureau Balto

15 Filed NOV 12 1927 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or Autopsy or Inquiry) thereon and from the evidence obtained ... find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhaling Illuminating Gas

(duration) Dead when found

CONTRIBUTORY (Secondary) ...

(Signed) Thos. B. Norton M. D.

(Coroner)

May 10-1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
National Cemetery	5/12/27

20 UNDERTAKER Sol Lennon & Bro ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22164

E 22164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1360 Andre St., 24-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Cardall

(a) RESIDENCE NO. 1428 Reynolds ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (~~HUSBAND~~ or) WIFE of Andrew Cardall

6 DATE OF BIRTH (month, day, and year) Mar. 14, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER August Raesler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Mayerski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Cardall (Address) 1428 Reynolds St

15 Filed MAY 12 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6 1927 to May 11 1927, that I last saw her alive on May 11 1927, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis = uraemia. Mitral regurgitation

(duration) 1 yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis

(Signed) Leo Schlenger, M. D.

19 (Address) 304 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus Cem

DATE OF BURIAL. May 14 1927

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1411 Bank St

Spec.-7-17-26—A Co.—200 Bks.

E 22165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 22165

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 616-N-Arlington-Av. St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Scervilia Nelson Holden

(a) RESIDENCE NO. 616-N-Arlington-Av. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. 10 mos. 20 ds. How long in U. S. if of foreign birth? 91 yrs. 10 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enoch Pratt Holden

6 DATE OF BIRTH (month, day, and year) June-20-1835

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	91	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Nelson

11 BIRTHPLACE OF FATHER (City or town) ? ?

(State or country) New York

12 MAIDEN NAME OF MOTHER Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Miss M. Elizabeth Holden (daughter)

(Address) 616-N-Arlington-Av. City

15 Filed MAY 12 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.M.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1927, to May 10, 1927.

that I last saw her alive on May 10, 1927.

and that death occurred, on the data stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

"Senility"

Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy. Examination, History

(Signed) John T. Shaw M. D.

5/11, 1927 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial May-13-27

20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOGDEN, Supervisor) — ADDRESS 108 W. NORTH AVE.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22166

CERTIFICATE OF DEATH

161-991

E 22166

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 242 S. Ann St., St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Gaczkowski

(a) RESIDENCE NO. 242 S. Ann St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
May 11, 1927.

7 AGE Years Months Days: 2 Hours

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Gaczkowski

11 BIRTHPLACE OF FATHER (City or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Dora Kowalska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Michael Gaczkowski
(Address) 242 S. Ann St.

15 Filed 2 1927 C. HAMPSON JONES, M. D., 17 Registrar
By R K H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 11, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 11, 19 27 to May 11, 19 27
that I last saw h alive on May 11, 19 27.
and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J. Reynolds M. D.

May 12 19 27 (Address) 804 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

Date of Burial: May 12 1927

20 UNDERTAKER: John M Weber

ADDRESS: 1803 Eutaw St

Spec.–7-17-26—A Co.—200 Bks.

E 22167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22167

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2606 Fleet St St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Severyna Szymanska

(a) RESIDENCE NO. 2606 Fleet St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	20	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Tin Decorating Co

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Szymanska

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Kapiszak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frances Szymanska

(Address) 2606 Fleet St

15 Filed MAY 21 1927 19 C. HAMPSON JONES, M. D. Registrar

Par 12 PH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/5, 1926, to 5/10, 1927.

that I last saw h alive on 5/10/27, 19

and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Pathological

(Signed) Hans Thiele, M. D.

, 19 27 (Address) 3325 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary Cem	May 14 1927
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

Spec.–7-17-26—A Co.—200 Bks.

22168

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 22168

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 718 N Washington St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wheeler

(a) RESIDENCE NO. 718 N Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry A. Wheeler

6 DATE OF BIRTH (month, day, and year): April 3 – 1873

7 AGE — Years: 54 Months: 1 Days: 8

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore

PARENTS

10 NAME OF FATHER: Conrad Bernhardt

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Helena Schmidt

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs Helena E Bulger

(Address): 718 N Washington St

15 Filed: MAY 12 1927

16 Registrar: C. HAMPSON JONES, M. D.

Plan: R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 – 1927

17 I HEREBY CERTIFY, That I attended deceased from May – 1926, to May 10 – 1927, that I last saw her alive on May 9 – 1927, and that death occurred, on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Asthma + Cirrhosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

19 (Address) 640 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: May 14 1927

20 UNDERTAKER: John Weems — ADDRESS: Cathedral

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22169

CERTIFICATE OF DEATH

129

E 22169

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 S. East Ave St.) (Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Vogel

(a) RESIDENCE NO. 132 S East Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Vogel

6 DATE OF BIRTH (month, day, and year): April 1 1847

7 AGE: Years 80 Months 1 Days 9

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Geo Vogel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Lena Vogel

(Address) 132 S East Ave

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 – 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7 1927 to May 10 1927

that I last saw h[illegible] alive on May 10 1927

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Ordema Pulmonis Complicating

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Landis M. D.

5/11. 1927 (Address) 3323 E Baltimore

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

Date of Burial: May 13 1927

20 UNDERTAKER: John Merrick

ADDRESS: 805 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22170

CERTIFICATE OF DEATH.

90 E 22170

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Duering

(a) RESIDENCE NO. Preston & Valley St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839 Oct 31st

7 AGE: Years 87 88 | Months 6 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Barron

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary C Connor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 May 12 1927 C. HAMPSON JONES, M. D.

Per R.K.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 11th

17 I HEREBY CERTIFY, That I attended deceased from Apr 19..., to ..., 19...,

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Mo Duration ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

May 12, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: May 13 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Greenmount Ave

Spec.–7-17-26—A Co.—200 Bks.

E 22171

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 22171

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1061 N. Linwood ave 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Baff

(a) RESIDENCE NO. 1061 N. Linwood ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Baff

6 DATE OF BIRTH (month, day, and year) Mar 5 1860

7 AGE Years 67 Months Days 5 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Andrew White

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lentsheu

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penn

14 Informant Katherine Baum

(Address) 1061 N. Linwood ave

MAY 2 1927 C. HAMPSON JONES, M. D. Registrar

Per RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 10-27 19

17 I HEREBY CERTIFY, That I attended deceased from April 5-27, to May 10-27, 19

that I last saw h alive on May 10-27,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Hermann, M. D.

, 19 (Address) 2136 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. Date of Burial May 13 1927

20 UNDERTAKER John A Moran ADDRESS 3002 E Balto

44

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22172

100-001

CERTIFICATE OF DEATH.

E 22172

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James Pratt

(a) RESIDENCE NO. 134 Dolphin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1925, to May 8, 1927, that I last saw h[illegible] alive on May 8, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Laboratory

(Signed) R Hampson Lamb, M. D.

May 11 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: May 12/927

20 UNDERTAKER: Daniel Easter ADDRESS: 916 Bank

Spec.—1-12-23—M&T—500 Bks.

E 22173

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22173

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 N Broadway ST., 7-13 WARD)

2-FULL NAME John Jos Petalesta

(a) RESIDENCE NO. 1038 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	48		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Drug Store

(c) Name of employer Deely & Poggi

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Petalesta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Poggi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Mary L Petalesta
(Address) 1038 N Broadway

15 Filed 21927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to May 10, 1927, that I last saw him alive on May 10, 1927, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Inarino, M. D.

May 10 1927 (Address) 1200 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5/13 1927

20 UNDERTAKER Chas. L. Carr & Son — ADDRESS 918 Park Ave

HAMPSON JONES, L. B.

Spec.—1-12-23—M&T—500 Bks.

E 22174

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital 11-24-29 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Miss Elizabeth Grace Burns

(a) RESIDENCE No. Sherwood Hotel (Usual place of abode) monument St. ST., ... WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mrs Wilkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs John A Patterson Baltimore Md

15 2 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1927. to May 12, 1927.

that I last saw her alive on May 11, 1927.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 13 1927
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son &	Balto Md

Spec.—1-10-21—M&T—1500 Bks. William Henry Syme ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22175 E 22175

CERTIFICATE OF DEATH.

129 12-44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Hadley Square, ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Syme

(a) RESIDENCE NO. 12 N. Hadley Square ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: French Shelton

6 DATE OF BIRTH (month, day, and year): Feb. 24, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: President

(b) General nature of industry, business, or establishment in which employed (or employer): Sea Gull Specialty Co.

(c) Name of employer

9 BIRTHPLACE (city or town): Petersburg

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Chapman J. Syme

11 BIRTHPLACE OF FATHER (city or town): West

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Julia B. Russell

13 BIRTHPLACE OF MOTHER (city or town): Petersburg

(State or country): Va.

14 Informant: Mrs. French S. Syme

(Address): 12 N. Hadley Square

Filed 2 1927 C. HAMPSON JONES, M. D.

PHR . 19 RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1926 to May 11 1927.

that I last saw h/Malive on May 11 1927.

and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2nd Hemorrhage

1st Hemorrhage Aug. 1925

(duration) yrs. mos. 6 wks. ds.

CONTRIBUTORY (Secondary) Chr. nephritis mitral stenosis

(duration) 1920 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs Blood test

(Signed) Emma Lutcher M. D.

. 19 (Address) 12 E. Eager St Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg, Va.

DATE OF BURIAL: 5/13 19 27

20 UNDERTAKER: Henry U. Mears & Son

ADDRESS: 805 N. Carlton

Via Penn R. R. - Mrs. Wm. H. Syme - Esco. To -

Cor.—12-9-25—A Co.—200 Bks.

E 22176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 E 22176

REGISTERED NO.

1-PLACE OF DEATH Pronounced Dead at
City of BALTIMORE: (No. Balto City Hospital St. 3-5 Ward)

2-FULL NAME Andrew Nini

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(8) RESIDENCE NO. 925 Eastern Ave St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1912

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	14	8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Gabriel Nini

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Christina Lamberti

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14
Informant Michael Nini
(Address) 925 Eastern ave

15 Filed ..... 1927 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation
(Inquest, autopsy or inquiry.) find that said deceased came to Accidental death
on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning
at Pier 4, East Falls way

Immediately
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenlon M. D.
(Coroner)

5/12. 1927 (Address) 700 Chaney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — Date of Burial May 14 1927

20 UNDERTAKER Wendell Dipple — ADDRESS 371 Conn

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22177

CERTIFICATE OF DEATH.

74001

E 22177

1-PLACE OF DEATH RAVENSWOOD AVE

City of BALTIMORE: (No. 639 Ravenwood St. 27-48 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs A. Perkins (PERKINS)

(a) RESIDENCE NO. 639 Ravenwood St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Levina B Perkins

6 DATE OF BIRTH (month, day, and year) 7/27/64

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Richmond Va

PARENTS

10 NAME OF FATHER John H Perkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Kedora Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Richmond Va

14 Informant Mrs Levina B Perkins

(Address) 639 Ravenswood Ave

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 7" 1925, to May 11 — 1927, that I last saw h— alive on 5/10 — 1927, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Whitridge Cook M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 5/13 1927

20 UNDERTAKER John F. Schryver ADDRESS 1318 Light St.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22178 70

CERTIFICATE OF DEATH.

× 32 E 22178

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT St. 9-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Imogene Dawn

(a) RESIDENCE NO. Belair Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): child

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19-1919

7 AGE: 8 Years | 1 Months | 23 Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Felix Dawn

11 BIRTHPLACE OF FATHER (city or town):

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER May Hayers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) North Carolina

14 Informant Records

(Address) JNS HOPKINS HOSPIT

15 Filed C. HAMPSON JONES, M. D. Registrar

2 1927 Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 12, 1927, that I last saw h.. alive on " ", 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Intracranial Tumor of Brain

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/1/27

Was there an autopsy? No

What test confirmed diagnosis? Thomas W. Cornwell, M. D.

(Signed) .....

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Date of Burial May 12 1927

20 UNDERTAKER: Dean & Foster ADDRESS Bel Air Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22179

CERTIFICATE OF DEATH.

E 22179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Lexington ST. Volunteers of America Hospital WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bennett

(a) RESIDENCE (Usual place of abode) No. Laurel Md ST., ... WARD .....
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hospital records.

Filed 1927. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 11, 1927, that I last saw him alive on May 11th, 1927, and that death occurred, on the date stated above, at 3.50 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas Herbert Wilkerson, M. D.

19 (Address) Walbert Apts Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Friday May 13 1927

20 UNDERTAKER Harry E. Witzke

ADDRESS 1531 N. Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22180

CERTIFICATE OF DEATH.

24001

E 22180

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1507 Glenwood Av. St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Carter

(Residence in Baltimore: No. 1507 Glenwood Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-~~Single, Married, Widowed, or Divorced~~, (Write the word.): married

6-DATE OF BIRTH: Feb (Month) 25 (Day) 1863 (Year)

7-AGE: 64 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Noah Howard.

(Address) 1503 Glenwood Ave.

15-

Filed MAY 13 1927, 192.....

C. HAMPSON JONES, M. D.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fr. Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Hollander M. D.
(Coroner.)

5/7 1927. (Address) 36 32 Roland Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Marys Hanover — DATE OF BURIAL: May 14, 1927

20-UNDERTAKER: Chenowith & Son — ADDRESS: 348 E Chestnut

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22181 — 1-PLACE OF DEATH

90 E 22181 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3221 Lyndale ave 8-40 WARD)

2-FULL NAME Elizabeth M. Prediger

(a) RESIDENCE NO. 3221 Lyndale ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Charles F. H Prediger

6 DATE OF BIRTH (month, day, and year) Aug 12 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
80	79	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Mundeim.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth M Mundeim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John L. Prediger. (Address) 3221 Lyndale ave

15 Filed MAY 13 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to May 10, 1927, that I last saw her alive on May 10, 1927, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Dis. Heart

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. Street, M. D.

5/12/27 (Address) 408 S Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery. DATE OF BURIAL: May 13 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Harford Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22182 — 90 — E 22182

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1905 E. Preston St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barry Sr.

(a) RESIDENCE NO. 1905 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Margaret Barry

6 DATE OF BIRTH (month, day, and year): Sept 1855

7 AGE — Years: 71 — Months: 8 — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired R.R. Engr 73

(b) General nature of industry, business, or establishment in which employed (or employer): Black & Sweetman Penn R.R.

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: John Barry

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Kath. Hartigan

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: John Barry Jr

(Address) 1905 E. Preston St. Balto

15 Filed ..... 1927 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4 1927 to May 10 1927

that I last saw h alive on May 9 1927

and that death occurred, on the date stated above, at 2 00 P.M.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

Infants' Paralysis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gradwohl

(Signed) J. Owen Dunphy M. D.

May 12 1927 (Address) 100 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — Date of Burial: 5/31 1927

20 UNDERTAKER: J. A. Moran — ADDRESS 3 and 28 Eutaw St

Duty important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22183 ✓ E 22183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 11-21 ST., 11 WARD)

REGISTERED NO. 200

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brice.

(a) RESIDENCE NO. Chesterton Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 20, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Millington, Md.

PARENTS

10 NAME OF FATHER Wm T. Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chestertown Md.

12 MAIDEN NAME OF MOTHER Aimee Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co, Md.

14 Informant Hospital Record

(Address)

15 Filed 4/22, 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1927

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to April 21, 1927, that I last saw him alive on April 21, 1927, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows;

Acute Appendicitis.

Peritonitis.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 13½ hrs.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 4/19/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampson Jones M. D.

4/21/27 (Address) 1 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Cemetery — DATE OF BURIAL Apr. 24 27

20 UNDERTAKER J. A. Tobin & Son — ADDRESS Mulberry

Cor.—12-9-25—A Co.—200 Bks.

E 22184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 E 22184

REGISTERED NO.

1-PLACE OF DEATH Found at foot of Broadway - Harbor

City of BALTIMORE: (No.) (St.) (Ward) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Paul Czinski

(a) RESIDENCE NO. 2623 Foster Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30-1903.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
23	24	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) MD.

PARENTS

10 NAME OF FATHER Matthew Poulczinski,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Victoria Mardos,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Victoria Poulczinski.

(Address) 2523 Foster Ave

15 Filed 5/13 1927 C. HAMPSON JONES, M. D. Registrar

Per K.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M. Hanlon M. D.
(Coroner)

5 12 1927 (Address) 702 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS, Date of Burial May 14. 1927.

20 UNDERTAKER M. F. Ludowski ADDRESS 908 S. Ann St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22185

CERTIFICATE OF DEATH.

9 E 22185

1-PLACE OF DEATH City of BALTIMORE: (No. Orchard Ave. near 5th St. Brooklyn. St. 25-75 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma K. Orr.

(a) RESIDENCE NO. Orchard Ave. near 5th St. Brooklyn. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced (or) WIFE of: James A. Orr.

6 DATE OF BIRTH (month, day, and year): March 11, 1862

7 AGE: Years 65 | Months 2 | Days 0 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): West Virginia.

PARENTS

10 NAME OF FATHER: Joseph Gardner.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): West Virginia.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Do not know.

14 Informant: James A. Orr. (husband)

(Address): Orchard Ave. Brooklyn.

15 Filed MAY 13 1927 C. HAMPSON JONES, M. D. Registrar

by R. C.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

5/12 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial: May 14 1927

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22186

CERTIFICATE OF DEATH

129 E 22186

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1400 Grace Court, St. Curtis Bay Ward) 25-11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Day

(a) RESIDENCE NO. 1400 Grace Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Day

6 DATE OF BIRTH (month, day, and year) Apr. 26, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Car & [illegible]

(c) Name of employer Foundry Co.

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Day

11 BIRTHPLACE OF FATHER (City or town) Baltimore,

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Fowler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,

(State or country) Md.

14 Informant Mrs. Clara Day

(Address) 1400 Grace Court Curtis Bay

15 Filed MAY 13 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1927, to May 11, 1927

that I last saw h[illegible] alive on May 10, 1927

and that death occurred, on the data stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Findings

(Signed) R. E. Campbell M. D.

May 11, 1927 (Address) 1644 Lancaster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial May 13 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Ly 6426

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

133 E 22187

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. (WARD)

2-FULL NAME John Geist

(a) RESIDENCE NO. Upper Co Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Geist

6 DATE OF BIRTH (month, day, and year) 6-22-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Abraham Geist

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Derby

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Hosp. Record
(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11 1927

17

I HEREBY CERTIFY, That I attended deceased from 4 20 , 1927 , to 5-11 , 1927.

that I last saw him alive on 5-11- , 1927.

and that death occurred, on the date stated above, at 6 00 P.m.

The CAUSE OF DEATH* was as follows:

Cystitis - Ulceration of Bladder

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Leukemia

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5-10-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. [illegible] M. D.

, 19 (Address) Maryland Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geists Cemetery Balto Co and

DATE OF BURIAL May 14 1927

20 UNDERTAKER J. F. Ellis & Sons

ADDRESS Residence

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22188

CERTIFICATE OF DEATH.

101-001

E 22188

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 24-34 Ward)

2-FULL NAME Miss Ruth Bone

(a) RESIDENCE NO. 1801 E. Biddle St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 5 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer) F. & C.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Lithuania

PARENTS

10 NAME OF FATHER Laib Bair

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Etta Millrit

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Lithuania

14 Informant Isaac Rubinstein

(Address) 1801 E. Baltimore St.

15 Filed _____, 19__ C. HAMILTON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/11/ 1927, to 5/12/ 1927, that I last saw her alive on 5/12/ 1927, and that death occurred, on the date stated above, at 8.20 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) _____

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Aaron, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Date of Burial 5/13 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22189

CERTIFICATE OF DEATH.

E 22189

1-PLACE OF DEATH 1111 Whitelock St

REGISTERED NO.

CITY OF BALTIMORE: (No. 1111 ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Blaustein

(a) RESIDENCE NO. 1111 Whitelock ST. WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Taube Blaustein
Taube

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Solaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Ladan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Taube Blaustein
(Address) 1111 Whitelock St

15 Filed 1927. 19 C. HAMPSON JONES, M. D.
Per — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-12-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan — 27 to May-12-1927.

that I last saw him alive on May-12-1927

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 4 mos 12 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none except Phys Exam.

(Signed) Herman Seidel M. D.

5/IV. 1927 (Address) 2404 Entawile

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. DATE OF BURIAL 5/13 1927

20 UNDERTAKER Jack Lewis ADDRESS 1409 E Balt St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22190

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 22190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 E. Baltimore ST., C-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asidor Goldman

(a) RESIDENCE NO. 1902 E. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Goldman

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 63 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Leha —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rose Goldman
(Address): 1902 E Balto St

15 Filed MAY 13 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/13/27 19

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to May 13, 1927, that I last saw h in alive on May 12, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): arteriosclerosis, chronic nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor J. Jung, M. D.

May 13 1927 (Address) 2036 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem DATE OF BURIAL: 5/13 1927

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22191

E 22191

PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Pronounced dead at Falls City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Benny

(a) RESIDENCE NO. 3503 Leverton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Benny

6 DATE OF BIRTH (month, day, and year) Oct 29. 1870

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	56	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House

(c) Name of employer Himelz

9 BIRTHPLACE (city or town) Falls City

(State or country)

PARENTS

10 NAME OF FATHER John Benny

11 BIRTHPLACE OF FATHER (city or town) Falls City

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Falls City

14 Informant Mary E. Benny

(Address) 3503 Leverton Ave

15 Filed ..... 19 ..... Registrar

HAMPSON JONES M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound through brain from self inflicted gun shot while in sane

(duration) ..... yrs. Instant mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Kenton M. D.

(Coroner)

May 14 1927 (Address) 7006 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 5/14 1927

20 UNDERTAKER Philip Herwig ADDRESS 2006 Orleans

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22192

CERTIFICATE OF DEATH

60-001 ✓ E 22192

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital

City of BALTIMORE: (No. 918 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Germack

(a) RESIDENCE NO. 1005 E. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jos. A. Germack

6 DATE OF BIRTH (month, day, and year) Oct. 1888

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	38	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Geo. Thurman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) 1005 E. Lanvale St

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

W 13 1927 By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927 to May 12th, 1927, that I last saw her alive on May 12th, 1927, and that death occurred, on the date stated above, at 6:25 A. m.

The CAUSE OF DEATH* was as follows:

Toxic Thyroid

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 5-9-27

Was there an autopsy?

What test confirmed diagnosis? Basal Metabolism

(Signed) Edmund T. H. Harrison Jr., M. D.

, 19 (Address) Woman's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial 5/16 1927

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Trischman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22193

E 22193

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Trischman

(a) RESIDENCE NO. 1234-2 Eager St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1864

7 AGE Years 63 Months 11 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Frank

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed NOV 13 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to May 11, 1927, that I last saw h.im alive on May 10, 1927, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

Myocardial hypertrophy (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general laboratory

(Signed) R. Hooper Smith, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Date of Burial 5/14 1927

20 UNDERTAKER P. Philip Henry ADDRESS 506 Orleans

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22194

CERTIFICATE OF DEATH.

X 18 E 22194

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Harbor Foot of Brag-4 St., _____ Ward)

2-FULL NAME Benj J. Grover

(a) RESIDENCE NO. Ft Howard Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 8 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 2 1883

7 AGE — Years: 44 — Months: 4 — Days: 5 7 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Soldier &c

(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Army

(c) Name of employer

9 BIRTHPLACE (city or town): Nashville Tenn.

(State or country)

PARENTS

10 NAME OF FATHER Nashville Tenn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Fort Howard Md

(Address)

15 Filed MAY 13 1927 C. HAMPTON JONES, M. D. Registrar

Floor R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1927

17 I HEREBY CERTIFY, That I held an inquest upon the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ____ yrs. ____ mos. ____ ds.

May 10 1927 (Signed) J C Blake M. D.

(Coroner)

(Address) 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial: 5/13/27

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS: 117 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22195

CERTIFICATE OF DEATH

E 22195

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 902 S. Seventh St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Toehrkolb

(a) RESIDENCE NO. 902 S. Seventh St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Toehrkolb

6 DATE OF BIRTH (month, day, and year) Nov. 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER John Toehrkolb

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Tertschbeck

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catharine Toehrkolb Wife

(Address) 902 S Seventh St.

15 Filed 19 Registrar C. HAMPSON JONES, M. D.

MAY 13 1927 Rec R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1926, to May 10, 1927, that I last saw him alive on May 7th, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Ritter, M. D.

19 (Address) 10 E Pattersn Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart, Cem	May 13 19 27

20 UNDERTAKER Kelly & Ziler

ADDRESS 403 N Howard St

Key: Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22196

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for the Aged of the M. E. Church

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fulton Ave & Franklin St. 95-7 WARD)

2-FULL NAME Laura J Owings

(a) RESIDENCE. NO. Fulton Ave & Franklin ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William

6 DATE OF BIRTH (month, day, and year) July 22 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Pell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Etta Cundy

(Address) 400 N Fulton Ave

15 FILED MAY 13 1927 C. HAMPSON JONES, M. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from August 1923 to May 11 1927

that I last saw h[illegible] alive on May 1927

and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.
Generalized Arteriosclerosis.
Chronic Nephritis
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration
(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Michel, M. D.

May 13 1927 (Address) 2401 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: May 13 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22197

CERTIFICATE OF DEATH.

100-001

E 22197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST. 21-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Eyler

(a) RESIDENCE NO. 1325 Sargeant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year): May 6, 1926

7 AGE — Years: 1 — Months: — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William A. Eyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marie Dellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records (Address): University Hosp.

15 Filed 6-3-1927 C. HAMPSON JONES, M. D. Registrar

Rec'r

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1927

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 12, 1927.

that I last saw him alive on May 12, 1927.

and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy.

(Signed) Elizabeth Sherman M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: 6/14 1927

20 UNDERTAKER: Harry W. Wirth 10-31 — ADDRESS: W. Fayette St

Cor.—12-9-25—A Co.—200 Bks.

E 22198

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

E 22198

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE. (No. 430-22½ St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Robert Norris

(a) RESIDENCE NO. 430 22½ st St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1901

7 AGE: Years 25 — Months 9 — Days 15 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Wm Norris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Mary Ellen Asbury

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Lucie Norris

(Address) 430 E 22½ St.

15 Filed....., 19..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dilation of Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Norris, M. D. (Coroner)

5/12, 19 27 (Address) 1322 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — Date of Burial: May 13 1927

20 UNDERTAKER: Daniel Easton — ADDRESS: 916 Park ave

Cor.—12-9-25—A Co.—200 Bks.

E 22199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 E 22199

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 N. Lexington St. 11-27 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Neal

(a) RESIDENCE NO. 1502 N. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23rd 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	3	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Richard Neal

11 BIRTHPLACE OF FATHER (city or town) N C
(State or country)

12 MAIDEN NAME OF MOTHER Jannie Grenge

13 BIRTHPLACE OF MOTHER (city or town) N C
(State or country)

14 Informant Jannie Neal

(Address) 1502 N. Lexington St

MAY 13 1927 HAMPSON JONES, M. D.

Filed ..... 1927 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) 2 hours

CONTRIBUTORY (Secondary) Heart failure

(Signed) Thos. B. Horton M. D.
Coroner

May 13 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. See Reverse Side for Additional Space.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 13/27

20 UNDERTAKER Daniel Carbin ADDRESS 916 Lee

Dr Fillow 315 S Highland Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 22200

CERTIFICATE OF DEATH

E 22200

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 17 S. Hare St. 1-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Theis

(a) RESIDENCE NO. 17 S. Hare St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Theis

6 DATE OF BIRTH (month, day, and year): Oct 14, 1853

7 AGE: Years 73 Months 6 Days 27 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Germany

PARENTS

10 NAME OF FATHER: Conrad Hild

11 BIRTHPLACE OF FATHER (City or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Minnie Haley

(Address) 17 S. Hare St

15 Filed ..... 19 .....

Registrar

MAY 13 1927 C. HAMPSON JONES

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to May 11, 1927, that I last saw her alive on May 11, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Gradual

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted unknown

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Thomas Talbot, M. D.

5/12, 1927 (Address) 315 S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz — Date of Burial: May 14 1927

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E Monument

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22201

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22201

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: No. 2436 East Monument St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Scroggs

(a) RESIDENCE NO. 2436 East Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie E Scroggs

6 DATE OF BIRTH (month, day, and year): April 10 1877

7 AGE — Years: 50 Months: 1 Days: 1 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman Shaw

(b) General nature of industry, business, or establishment in which employed (or employer): Flat Company 086

(c) Name of employer: Townsend Grace Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Scroggs

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Minnie E Scroggs

(Address) 2314 Elmora Ave

15 Filed ____ 19 ____ (HAMPSON JONES, M. D.) Registrar

MAY 13 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 11th 27

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to May 11, 1927; that I last saw him alive on May 11, 1927, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ____ yrs. ____ mos. 8 ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) ____ yrs. ____ mos. 7 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan H Shpritz M. D.

May 12, 1927 (Address) 1830 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: 5/14 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

332 N. Patterson Pk. 124 Locher

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22202

CERTIFICATE OF DEATH

E 22202

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 S Castle St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S Longwath

(a) RESIDENCE No. 206 S Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret A Longwath

6 DATE OF BIRTH (month, day, and year): July 16 1858

7 AGE: Years 68 Months 10 Days 19

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laboring

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: None

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER: Lawson Longwath

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Emma Wolferman

(Address) 206 S Castle St.

15 Filed MAY 13 1927

16 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/1/27, 1927, to 5/12/27, 1927.

that I last saw him alive on 5/11/27, 1927.

and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory by Cirrhosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

5-17-27 (Address) 926 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lamel

Date of Burial: May 15 1927

20 UNDERTAKER: Hillman Carson & Martin

ADDRESS

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22203 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO. 177

CITY OF BALTIMORE: (No. 2169 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna L. Bentelspacher

(a) RESIDENCE NO. 529 S. Catherine St. or Agnes, WARD St. Josephs Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Harry Bentelspacher

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter. F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna L Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Harry. Bentelspacher. (Address) 529. S. Catherine ave.

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to May 11, 1927, that I last saw her alive on May 11, 1927, and that death occurred, on the date stated above, at 8.35 p.m.

The CAUSE OF DEATH* was as follows:

1 Bichloride of Mercury Poisoning — Accidental

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 4 ds.

Where was disease contracted if not at place of death? at home.

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) A. J. Knapp, M. D.

5-11, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery. DATE OF BURIAL May 16 1927

20 UNDERTAKER George F. Frost ADDRESS 1735 Harford ave.

Spec.—8-24-14—M. & T.—2000 Bks.

E 22204

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22204

CERTIFICATE OF DEATH.

161-22

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 - So. 17th. St. 21-39 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Fitzgerald

(Residence in Baltimore: No. 512 S. - 17th St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May (Month) 12 (Day), 1927 (Year)

7-AGE, ...yrs....mos. * ds.

If LESS than 1 day, 3 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Wm Fitzgerald

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Julia Kenney

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Fitzgerald

(Address) 512 S 17th St

15- Filed ....., 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1927, to May 12 1927, that I saw him alive on May 12 1927, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Prolapsed Cord.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Obs. Labor

(Duration) ....yrs....mos....ds.

(Signed) Thomas H. Magruder M. D.

5/13, 1927 (Address) 111 E. Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cem. DATE OF BURIAL. May 13. 1927

20-UNDERTAKER Cohenour & Son ADDRESS 317 Chestnut

Spec.—1-12-23—M&T—500 Bks.

E 22205 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22205

CERTIFICATE OF DEATH.

101-21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital — ST., 21-24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Mack

(a) RESIDENCE NO. 1234 N. Custer ST., Oxford WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Mack

6 DATE OF BIRTH (month, day, and year) Nov. 2nd 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	-	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Chas. Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Barnett Mack

(Address) 1234 N Custer St

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D., Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1927, to May 13, 1927, that I last saw h. alive on May 13, 1927, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos. B. Turner, M. D.

5-13, 1927 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westen

DATE OF BURIAL May 16 1927

20 UNDERTAKER Chas. J. Kalis

ADDRESS 1200 W Lombard St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22206

CERTIFICATE OF DEATH.

113.

E 22206

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1107 Union Ave. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Louis Hartmann

(a) RESIDENCE NO. 1107 Union Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28 - 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Fred K Hartmann

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Indiana

12 MAIDEN NAME OF MOTHER Thelma Rafft

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Thelma Hartman

(Address) 1107 Union Ave

15 Filed G. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

Found dead

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

(Address) May 13-27 Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial May 1927

20 UNDERTAKER John Stricker ADDRESS W. Lombard St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22207 ✓ E 22207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH—Dr. White's Private Hospital 162

CITY OF BALTIMORE: (No. 1029 Madison Avenue ST. 17 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Clifton Davis

(a) RESIDENCE NO. 1108 Druid Hill Ave ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	✓		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Clifton Davis

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Rosa Henry

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) S. C.

14 Informant .....
(Address)

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

3 1927 1351

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to May 13, 1927.

that I last saw him alive on May 12, 1927

and that death occurred, on the date stated above, at 4: A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. C. Cassedy, M. D.

, 19 (Address) 753 George St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL MAY 13 1927

Commissioner Health.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22208 HEALTH DEPARTMENT—CITY OF BALTIMORE

101 E 22203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1926 E. 28th St. (Ward) 9-46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Korolus.

(a) RESIDENCE. No. 1926 E. 28th St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Korolus.

6 DATE OF BIRTH (month, day, and year) July 27 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Mantel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rothmund.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Korolus.

(Address) 1926 E. 28th St.

15 Filed MAY 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2. 1927. to May 11. 1927.

that I last saw her alive on May 11. 1927.

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M D

5/11, 1927 (Address) 9818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 14 1927

20 UNDERTAKER Mrs. Mrs. John H. Feigel & Son ADDRESS 501 W. Fayette

(See Letter in file and Affidavit dated May 20-1927)

Spec.—12-9-25—A. & P.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22209

CERTIFICATE OF DEATH.

E 22209

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 1600 Ward)

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Edward O. Hanlon also known as Omar Franklin Burrell

(a) RESIDENCE NO. 1700 E. 30th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pearl Hanlon

6 DATE OF BIRTH (month, day, and year): Apr 19. 1885

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
42	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Taxicab Business

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Harrington

(State or country) Del

PARENTS

10 NAME OF FATHER: Wm. Hanlon

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Del

12 MAIDEN NAME OF MOTHER: Rachael E. Pleasanton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Del

14 Informant: Pearl Hanlon

(Address) 1700 E. 30th St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 12

17 I HEREBY CERTIFY, That I attended deceased from Apr. 19 1927, to May 12, 1927; that I last saw him alive on May 12, 1927, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Clark Grove, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila Pa Date of Burial May 14, 1927

20 UNDERTAKER: Mc Mus. J. W. Teufel & Son ADDRESS 801 W Fayette

Spec.—12-9-25—A Co.—200 Bks.

E 22210

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22210

CERTIFICATE OF DEATH.

× 129

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 258 Robert St. 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. W. Frazier

(a) RESIDENCE NO. 258 Robert St. Ward Brookville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan A Frazier

6 DATE OF BIRTH (month, day, and year): March 13 1862

7 AGE: Years 65 Months 2 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Himself.

9 BIRTHPLACE (city or town)

(State or country) Montgomery Co. Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Don't Know

14 Informant Constantia Frazier

(Address) 258 Robert St

Rec'd 3 1927 C. HAMPSON JONES, M. D. Registrar

Rec KRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1927, to May 12, 1927, that I last saw h[illegible] alive on May 12, 1927, and that death occurred, on the date stated above, at 11:55 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

5/13, 1927 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brook Grove Cem Md Date of Burial May 15 27

20 UNDERTAKER: Samuel F. Stensley ADDRESS 518 N Bdde

Spec.—12-9-25—A Co.—200 Bks.

E 22211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 22211

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2036 McCleary St., 7-11 Ward)

2-FULL NAME Harry J. Beatty

(a) RESIDENCE NO. 2036 McCleary St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alma Beatty

6 DATE OF BIRTH (month, day, and year): Sept. 27. 1861

7 AGE: Years 65 yrs. | Months 8 mo. | Days 16 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: William P. Beatty

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mrs. Grant

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs. Alma Beatty

(Address): 813 McCleary St

MAY 13 1927 C. HAMPSON JONES, M. D. Registrar

Fee Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 27, to May 13, 19 27, that I last saw h.. alive on May 12, 19 27, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

from Contributory Cause

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Grahame M. D.

May 13 1927 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Lorraine Cem. May 16 1927

20 UNDERTAKER: John C. Miller ADDRESS: 2435 E Oliver St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22212 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1111 Hanbrooke St., 21 Ward. Registered No. 1601

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bengtoed

(a) Residence No. 1111 Hanbrooke St., 21 Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced. (Write the word.): Single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: None

6-DATE OF BIRTH (month, day and year): May 12. 27

7-AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day: 10 hrs. 35 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Edw G. Bengtoed.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Thelma Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-(Informant): Edw G Bengtoed

(Address): 1111 Hanbrooke St

15-Filed: 4 1927 19.. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 13. 27

17-I HEREBY CERTIFY, That I attended deceased from May 12 19 27 to May 13 19 27

that I last saw him alive on May 12 19 27

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

If-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John G. Schwerenbrun M. D.

19 (Address) 11 New Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: May 14th 19 27

20-UNDERTAKER: E Schlosnagle Son — ADDRESS: Fremont Ave

Spec.–7-17-26—A Co.—200 Bks.

Herzog

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22213 46 E 22213

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Balto city Hospital 12-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Herzog -

(a) RESIDENCE NO. 617 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Herzog

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50 Months Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Dennis Dugan

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland.

14 Informant: Mrs Catherine Kelly

(Address): 817 Hanover St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Filed 4 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-12-27

17 I HEREBY CERTIFY, That I attended deceased from 5-10- 1927, to 5-12- 1927

that I last saw h[illegible] alive on 5-12 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Ovary -

[illegible] ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. Hugues, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — Date of Burial: May 16 1927

20 UNDERTAKER: F. A. Kramer & Son — ADDRESS: 703 Hanover St.

Spec.—1-12-23—M&T—500 Bks.

E 22214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 22214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3714 Sequoia Ave ST. 15-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Madeline Burnett

(a) RESIDENCE No. 3714 Sequoia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Burnett

6 DATE OF BIRTH (month, day, and year): May 8, 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
88		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. Chason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Mary Lans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Jos. O. Burnett

(Address) 3714 Sequoia Ave

Filed 1927 C. THOMPSON JONES, M. D.

Registrar RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1927

17

I HEREBY CERTIFY, That I attended deceased from 1924 to May 12 1927

that I last saw h[illegible] alive on May 11 1927

and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Joseph Wisely M. D.

(Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cem

DATE OF BURIAL: 5/14 1927

20 UNDERTAKER: W. J. Pickar Sons

ADDRESS: Penna Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22215

CERTIFICATE OF DEATH.

179 E 22215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 1-66 Ward)

2-FULL NAME Gertrude Marion Holbrook

(a) RESIDENCE NO. 2816 W. Lafayette Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 8 mos. 19 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augustus D. Holbrook

6 DATE OF BIRTH (month, day, and year): Aug 24 1872

7 AGE: Years 54 Months 8 Days 19

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Richard K. Heckels

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Julia Long

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Mrs. Augustus D. Holbrook

(Address): 2816 W. Lafayette Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq 7 (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq 7 (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dementia following

Burns of body (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clement [illegible] M. D.

(Coroner)

, 19 2 (Address) 3328 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial: May 6 192 7

20 UNDERTAKER: W. M. Fletcher Sons ADDRESS: Norelta

Plot

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22216 E 22216

CERTIFICATE OF DEATH.

REGISTERED NO. 20-725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Shearer

(a) RESIDENCE NO. 2793 Wilkens Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant daughter Mrs. F. Bell

(Address) 2456 Carpenter St

15 Filed , 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 1927, to 5-13, 1927, that I last saw h~~e~~ alive on 5-13, 1927, and that death occurred, on the date stated above, at 3 10 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene of leg

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northwood Cem Phila, Pa.

DATE OF BURIAL 5/17/1927

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22217 101-2 E 22217

CERTIFICATE OF DEATH.

REGISTERED NO. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Harwood Ave ST., WARD)

2-FULL NAME Phebe Yates Lazarus

(a) RESIDENCE NO. 506 Harwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1871

7 AGE 55 Years 11 Months 13 Days

~~50~~ 10 17

If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Specialty Kitchen Ware

(b) General nature of Industry, business, or establishment in which employed (or employer) Shop

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edgar M. Lazarus

11 BIRTHPLACE OF FATHER (city or town) Charleston
(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Fannie Andrews

13 BIRTHPLACE OF MOTHER (city or town) Charleston
(State or country) S. Carolina

14 Informant Ewalt Lazarus
(Address) 506 Harwood Ave

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1927, to 5-13, 1927,
that I last saw h[illegible] alive on 5-12, 1927,
and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA

(duration) — yrs. — mos 12 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Dorsey, M. D.

, 19 (Address) 1129 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation Loudon Park — DATE OF BURIAL 5/14 1927

20 UNDERTAKER Henry W. Jenkins & Son Co. — ADDRESS Orchard & McCulloh Sts

Spec.—1-12-23—M&T—500 Bks.

E 22218

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22218

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 14 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Massenburg

(a) RESIDENCE NO. 526 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of James Massenburg.

6 DATE OF BIRTH (month, day, and year) May 13 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Indie Wicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm Seaton (Address) 526 N Stricker

15 Filed 4 1927 C. HAMPSON JONES, M. D. , 19 RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13-27

17

I HEREBY CERTIFY, That I attended deceased from 4-13-27 19 , to 5-13-27 , 19 ,

that I last saw h alive on 5-13-27 , 19 ,

and that death occurred, on the date stated above, at 12:00 noon

The CAUSE OF DEATH* was as follows:

Hypertension Nephritis
arterial Sclerosis
Myocarditis
unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) absent

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) E.R. Miller, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cape Charles Va — DATE OF BURIAL 5/14 1927

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1723 Eastland Ave

Spec.–7-17-26—A Co.—200 Bks.

E 22219

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22219

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 10-59

City of BALTIMORE: (No. 2510 Brookfield Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Myer

(a) RESIDENCE NO. 2510 Brookfield Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie D. Myer

6 DATE OF BIRTH (month, day, and year) Nov. 2nd. 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Bernhard Myer

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Blumenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Hattie D. Myer

(Address) 2510 Brookfield Ave.

15 [illegible] 1927 C. H. MPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1927, to May 11, 1927, that I last saw him alive on May 11, 1927, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Polypi in the Urinary Bladder

(duration) 20 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Pathological

(Signed) Jos. H. Zierler. M. D.

5/12/ 1927 (Address) 1123 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oheb Shalom Cemetery	5/15/ 1927
20 UNDERTAKER David Sondheim	ADDRESS 116-20 W. Mt. Royal Ave.

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22220

CERTIFICATE OF DEATH.

90 E 22220

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO._____

City of BALTIMORE: (No. [redacted] St., 64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Mahon

(a) RESIDENCE NO. 17 N. Dallas St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Gaston Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Agnus ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) [redacted]

15 Filed ..... 19 ..... Registrar

BALTIMORE CITY HOSPITALS
C. HAMPSON JONES, M. D.
1352

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1926, to May 10, 1927, that I last saw h.a. alive on May 9, 1927, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) .....yrs. .....mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & laboratory

(Signed) R. Hooper Smith, M. D.

May 11 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or, in Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial MAY 13 1927 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

Cor.—12-9-25—A Co.—200 Bks.

E 22221

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. South Baltimore General Hospital 11-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Monty Edwards.

(a) RESIDENCE NO. Wallace, Idaho. Temporary, Pimlico Race track. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jockey.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wallace, Idaho.

(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Walter A. Carter. (trainer)

(Address) 9447-216th St. Queens village Long Island. N.Y.

15 Filed MAY 14 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and internal injuries. Accidental fall from a horse during race.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) Chas. A. Reinhardt M. D.
(Coroner)

5/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ... ds. In the State ....yrs., ...mos., ... ds.

Where was disease contracted, if not at place of death? Pimlico Race track. May 12, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spokane, Wash Date of Burial May 14 1927

20 UNDERTAKER John H. Denny ADDRESS 715 Light

Spec.—1-12-23—M&T—500 Blks.

E 22222

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22222

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 229 S. Gilmor ST. 14-28 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Deets

(a) RESIDENCE NO. 229 S. Gilmor ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yr. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Ida Cromer

(Address) 1625 Edmondson Ave

15 Filed ....., 19 ..... Registrar

4-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1925, to May 12, 1927,

that I last saw her alive on May 11, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis + interstitial nephritis. —

(duration) Several yrs. — mos — ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bowman Lloyd, M. D.

5/12, 1927 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL May 14 1927

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22223

CERTIFICATE OF DEATH.

161-00

E 22223

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St. 7-9 Ward)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. Aberdeen Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race Male Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1927

7 AGE Years 0 Months Days IF LESS than 1 day 2 hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Elenor Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) Johns Hopkins Hospital.

15 Filed 4 1927, 19 C. HAMPSON JONES, M. D. Registrar

1354 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 19 27, to 5-8, 19 27, that I last saw ~~him~~ alive on 5-8, 19 27, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia livida

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Prolonged labor

(duration) ___ yrs. ___ mos. ___ ds.

Antepartum administration of morphia to mother.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Yes Date of 5/8/27

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J K Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL MAY 14 1927

Commissioner of Health

Spec.—12-9-25—A Co.—200 Bks.

E 22224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward) 8-17

2-FULL NAME Charles Buchta

(a) RESIDENCE NO. 1619 N. Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George P. Buchta

11 BIRTHPLACE OF FATHER (city or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Glocker

13 BIRTHPLACE OF MOTHER (city or town) ? Md.

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Woods

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to May 12, 1927, that I last saw him alive on May 11, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Neoplasm of Cerebrum (left) over

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? gen'l & laboratory

(Signed) R. Hooper Smith, M. D.

(Address) BALTIMORE CITY HOSPITALS May 12 1927

*State the Disease [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial May 14th 1927

20 UNDERTAKER Henry Hood Son ADDRESS 1501 E. Eager St.

Spec.—1-12-23—M&T—500 Bks.

E 22225

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22225

CERTIFICATE OF DEATH.

X 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. ST. 1751 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Johnson

(a) RESIDENCE NO. 119 W 21st St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: L

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (State or country): Va.

10 NAME OF FATHER: Thos Jefferson

11 BIRTHPLACE OF FATHER (State or country): Gloucester Virginia

12 MAIDEN NAME OF MOTHER: Estelby Jones

13 BIRTHPLACE OF MOTHER (City or town) Gloucester (State or country) Virginia

PARENTS

14 Informant: Virginia Lee Tolmo allyn

(Address) 7451 N Calvert St

15 Filed 5/12, 19 27

Registrar: WM. C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/9, 1927, to 5/12, 1927, that I last saw her alive on 5/12, 1927 and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy shock 2 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/12/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical history

(Signed) Amanda Johnson, M. D.

(Address) W. Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gloucester Court Va. DATE OF BURIAL 5/14, 1927

20 UNDERTAKER: Samuel A Kinsley ADDRESS 781 N Gilmore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22226 ✓ E 22226

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 S. Sharp St. St., 23-31 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Dixon.

(a) RESIDENCE NO. 915 S. Sharp St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married.

5a If married, widowed or divorced Husband of Eva Dixon.(C)

6 DATE OF BIRTH (month, day, and year) February 9, 1889.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	88	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher.

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Dixon.(C)

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Keys.(C)

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Baltimore, Md.

14 Informant Eva Dixon.(C) wife.

(Address) 915 S. Sharp St.

4 1927, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphilitic Meningitis, with obliteration of foramen at base Diagnosis confirmed by microscopic sections

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) _____

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Pernkandl M. D. (Coroner)

May 14, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 5/14 1927

20 UNDERTAKER Samuel Hunter ADDRESS Laurel

Cor.—12-9-25—A Co.—200 Bks.

22227

HEALTH DEPARTMENT—CITY OF BALTIMORE

148E 22227

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Home St., 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Smith

(a) RESIDENCE NO. 904 Pearl St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Smith

6 DATE OF BIRTH (month, day, and year) March 10 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Easterville Va.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Richard Smith

(Address) 904 Pearl St.

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous nephritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pregnancy 5 mos.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 14 192 7 (Address) 2801 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 NAME AND LOCATION OF CEMETERY Odd Fellows Chapel Easterville Md. Date of Burial 5/14 1927

20 UNDERTAKER Samuel Hensley ADDRESS 778 E Baltimore St

1927 HAMPSON JONES M.

Spec.—1-10-21—M&T—1500 Bks.

E 22228 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22228

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 628 (ST.) George (WARD) 17-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Briscoe

(a) RESIDENCE NO. 628 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Gilbert Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marie Brown

(Address) 628 George St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 11, 1927, that I last saw him alive on May 11, 1927, and that death occurred, on the date stated above, at 4.35 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank E. Trag M. D.

5/14/1927 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 5/14/27

20 UNDERTAKER Samuel Brinsley — ADDRESS 628 Saddle

MAY 13 1927 C. HAMPSON JONES, M. D.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22229

CERTIFICATE OF DEATH

129 E 22229

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 807 Chauncey Ave. St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave B. Gomprecht

(a) RESIDENCE NO. 807 Chauncey Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Gomprecht

6 DATE OF BIRTH (month, day, and year) April 12th. 1858.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Bernard Gomprecht

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophie Rosenthal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Bernard Gomprecht

(Address) 807 Chauncey Ave.

15 Filed 4 1927 19

C. HAMPSON JONES, M. D. Registrar

By RKN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to 13 May, 1927, that I last saw him alive on 13 May, 1927, and that death occurred, on the data stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Exam and Laboratory

(Signed) Horace W. Byers, M. D.

, 19 (Address) 214 West Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cheb Shalom Cemetery	5/15/ 1927
20 UNDERTAKER	ADDRESS
Harid Sondheim	1128 Druid Park Lake Ave

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 22230

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Green St. Ward 7 + 24)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Schoen

(a) RESIDENCE NO. 1116 Hanticoke ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Late John Schoen

6 DATE OF BIRTH (month, day, and year) Sept 26 1858

7 AGE Years 68 Months 7 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER August Bernhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Hackley Schoen

(Address) 1116 Hanticoke st

15 Filed MAY 14 1927 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 12, 1927, that I last saw her alive on May 12, 1927, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs

Signed Wallace Walker M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL May 16 1927

20 UNDERTAKER Jos Jos Sons & Son

ADDRESS 217 S. Paca St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22231

CERTIFICATE OF DEATH.

66

E 22231

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1304 N. Fremont St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hymes

(a) RESIDENCE NO. 1304 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): About 1867

7 AGE: Years: About 60 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mason

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Corey Hines

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Do not know

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Rev. C. F. Morrison

(Address): Gilmor & Baker Sts.

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

By: RRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Kearney, M. D. (Coroner)

May 13, 1927 (Address) 202 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters — Date of Burial: May 14, 1927

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1527 N. North

Very important—See instructions on back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22232
1-PLACE OF DEATH

90 E 22232
REGISTERED NO.

City of BALTIMORE: (No. 1131 Valley St St 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Gaffney

(a) RESIDENCE NO. 1131 Valley St St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) Jan 24/1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Hollins Market
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

10 NAME OF FATHER Thos. Gafney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

PARENTS

14 Informant Miss Ann Gaffney
(Address) 1131 Valley St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr. Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paul M. D.
(Coroner)
5/14/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial May 16 1927

20 UNDERTAKER Rita Redefeld ADDRESS 9 + Fremont Ave

MAY 15 1927 HAMILTON JONES, M. D. Registrar

Spec.—1-12-23—M&T—500 Blks.

22233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+47 E 22233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hodges

(a) RESIDENCE NO. Annapolis, Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 6 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Hodges

6 DATE OF BIRTH (month, day, and year) June 22, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

PARENTS

10 NAME OF FATHER Richard Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Maryland

12 MAIDEN NAME OF MOTHER Henrietta Worsellle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Sallie R. Groff

(Address) Owings Mills, Md.

15 Filed MAY 5 1927, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1926 to May 14, 1927, that I last saw her alive on May 14, 1927, and that death occurred, on the date stated above, at 4.55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mediastinal glands

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinically & X-ray

(Signed) R. S. Anderson, M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prince Frederick, Calvert Co. DATE OF BURIAL 5/16, 19 27

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert

Spec.—12 9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22234 E 22234

CERTIFICATE OF DEATH.

× 101-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 S. Chester St St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zofia Gos

(a) RESIDENCE NO. 414 S Chester St., Ward Poland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4 NOV 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	7 6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Frank Gos

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Poland

12 MAIDEN NAME OF MOTHER: Francis Zgak

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Frank Gos

(Address) 414 S Chester

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13. 27 19

17 I HEREBY CERTIFY, That I attended deceased from May 3 19 27 to May 13 19 27, that I last saw h[illegible] alive on May 13 19 27, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilat

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Gracek M. D.

(Address) 501 E Fredrick No. 147

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem Date of Burial 5-16 1927

20 UNDERTAKER: Stephen J Falkowski ADDRESS 5 Fremont

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22235

E 22235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13th St near Washington Blvd ST., 26-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Matoska.

(a) RESIDENCE NO. 13th St. near Washington Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Matoska

6 DATE OF BIRTH (month, day, and year) Aug 9/81

7 AGE Years 45 Months 8 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector of H.W. Heaters

(b) General nature of industry, business, or establishment in which employed (or employer) Hot Water

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Matoska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Theresa Moroatral

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Matoska (Address) 13th St near Washington Blvd. Balto. Morrill 02

15 Filed MAY 15 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1927 to Present 19 that I last saw him alive on May 14, 1927 and that death occurred, on the date stated above, at 12.15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic tabular heart disease.

Aneurysm.

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Sues (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassermann

(Signed) Wm. A. Stanos M. D.

5/15/27 19 (Address) 1201 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill

DATE OF BURIAL 5/18 1927

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22236

CERTIFICATE OF DEATH.

129 E 22236

REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver (ST.) 26-36 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Schluderberg—

(a) RESIDENCE NO. 12th ave. 19th St Colgate (ST.) near Riverview (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word): married—

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lena Schluderberg—

6 DATE OF BIRTH (month, day, and year): May ? 1862

7 AGE: Years 65 | Months 0 | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman— 06 ✓

(b) General nature of industry, business, or establishment in which employed (or employer): U-R R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Georg Schluderberg—

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lena Schluderberg (Address) 12th Ave & 19th St. Colgate Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May, 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 14, 1927, that I last saw h[illegible] alive on May 14, 1927, and that death occurred, on the date stated above, at 8:35 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis, Chr. Nephritis.
Hypertension —
Ascites.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical.

(Signed) Frank R. DeSarla M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz

DATE OF BURIAL: 5/17 1927

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Aliceanna St

Spec.—1-10-21—M&T—1500 Blks.

E 22237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22237

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 2117

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Santa Santonocita

(a) RESIDENCE NO. 221 S. Clinton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 16 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Santanocita

6 DATE OF BIRTH (month, day, and year) June 3, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Mylong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Chart

(Address)

Filed MAY 15 1927 H. HAMILTON JONES, M. D. Registrar

Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/7, 1927, to 5/12, 1927.

that I last saw her alive on 5/12, 1927.

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis. chronic cholangitis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) cardiac failure

(duration) ..... yrs. ..... mos. 1 day

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/12/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jno A Sampson, M. D.

, 19 (Address) John Santanocita

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 17 1927

20 UNDERTAKER Frank V. Pikitone

ADDRESS 2818 E. Biddle St

Spec.—12-9-25—A Co.—200 Bks.

202684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 22238

E-[illegible]22238 DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Corkeran

(a) RESIDENCE NO. 164 Hillhare St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-11-27

7 AGE: Years — Months — Days: 3 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER John Corkeran

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Lillie Knehn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 15 1927, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to May 14, 1927, that I last saw h[illegible]alive on May 14, 1927, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar.

(duration) yrs. mns. 7 ds.

CONTRIBUTORY (Secondary) Syphilis, congenital

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harvey W. Cowdell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Redeemer Date of Burial May 16 1927

20 UNDERTAKER: John J. Kerr ADDRESS 156 N. Luzerne

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22239 — REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 6-9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dougherty

(a) RESIDENCE NO. 2034 N. Chapel St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Dougherty

6 DATE OF BIRTH (month, day, and year) July 3, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Kingan Provision Co.

(c) Name of employer Holiday & Hamt.

9 BIRTHPLACE (city or town) Penn-

(State or country)

PARENTS

10 NAME OF FATHER Bernard Dougherty

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) Md-

(State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10 1927, to May 14, 1927, that I last saw him alive on May 14, 1927, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute lobar

Septicemia, Streptococcus

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture - Autopsy

(Signed) Christopher Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery Holy Cross Harford Rd. Date of Burial May 18 1927

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E. Eager St.

MAY 15 1927 R.K.

Spec.—1-12-23—M&T—500 Bks.

E 22240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22240

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Bon Secours Hospital 15-56 REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Nathan Klaff

(a) RESIDENCE No. 3425 Reisterstown Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Eva Klaff

6 DATE OF BIRTH (month, day, and year) July 9-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Henry Klaff

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Amatt

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Eva Klaff

(Address) 3425 Reisterstown Rd

15 Issued 5 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1927, to May 13, 1927, that I last saw him alive on May 13, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Infiltrating Glioma of left cerebral hemisphere Recurrent

(duration [?]) 1 yrs. mos ds

CONTRIBUTORY (Secondary) Post operative shock 2 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of { Feb. 3, '27 / May 13, '27

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operative.

Signed Geo. D. Liffey, M. D.

5/13 1927 Address Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Md DATE OF BURIAL 5/15 1927

20 UNDERTAKER Jack Lewis 1429 Gilmor St ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2024 5-3 E 22241

CERTIFICATE OF DEATH.

155 E 22241

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St. _____ Ward) 6-10

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ferretie

(a) RESIDENCE NO. 223 N. Port St St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) April 22 - 1927

7 AGE: Years | Months | Days 21 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work osd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Ferretie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Banton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt md

14 Informant Parents

(Address) Johns Hopkins Hospital

15 Filed ..... (19) ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22 1927, to May 13, 1927, that I last saw her alive on May 13, 1927, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Acute epiphysitis, left shoulder

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis Septicaemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: 5/16 1927

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balt St

Spec.—1-12-23—M&T—500 Bks.

E 22242

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22242

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp'l ST., WARD)

2-FULL NAME William Grossman

(a) RESIDENCE NO. 2349 W. North ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Grossman

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Grossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Untown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Grossman

(Address) 2349 W North ave

15 Filed MAY 15 1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to May 14, 1927, that I last saw him alive on May 14, 1927, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hosp'l

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 5/15 1927

20 UNDERTAKER Jack Levis 1439 Eutaw — ADDRESS

Spec.—1-12-27—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22243

CERTIFICATE OF DEATH.

1549-003

E 22243

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. 325 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boby Katzen

(a) RESIDENCE NO. 1401 E. Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/11/27

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joe Katzen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): West Baltimore Gen. Hosp

15 Filed JUN 1927, 19 C. HAMPSON JONES, M. D. Registrar

By R L

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/11, 1927, to 5/13, 1927, that I last saw her alive on 5/13, 1927, and that death occurred, on the date stated above, at 5 00 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Ventral Hernia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/13/27

Was there an autopsy? no

What test confirmed diagnosis Clinical Appearance

(Signed) Orville F. Jensen, M. D.

5/15, 1927 Address West Bal. Ga. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Cem. DATE OF BURIAL 5/15 1927

20 UNDERTAKER: D. Jack Lewis ADDRESS 1409 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 22244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001

E 22244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. W-30 (WARD)

2-FULL NAME Katherine Weitzel.

(a) RESIDENCE NO. Kenwood ave ~~Belmont~~ ST., Elmont ave. WARD Averlea

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9y yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of William H. Weitzel

6 DATE OF BIRTH (month, day, and year) Jan. 25th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Schell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William H. Weitzel (Address) Averlea Md.

15 Filed MAY 5 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/27

17

I HEREBY CERTIFY, That I attended deceased from 4/29/27, 19, to 5/13/27, 19,

that I last saw her alive on 5/13/27, 19,

and that death occurred, on the date stated above, at 8 50 a.m. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Bleeding Hemorrhoids

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Multiple skin Infections Seven days duration

(duration) yrs. mos. ds.

Septicemia of Five days duration

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/11/27

Was there an autopsy? Incision & drainage of abscess no

What test confirmed diagnosis? Blood Picture culture

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL May 17 1927

20 UNDERTAKER Frederick Lassahn & Sons

ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22245

CERTIFICATE OF DEATH.

E 22245
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Home.

CITY OF BALTIMORE: (No. 4019- Roland Ave ST. 13-52 WARD)

2-FULL NAME Martha G. Blakeney.

(a) RESIDENCE NO. 4019- Roland Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. 68 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 23-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John D. Blakeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Gaynt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Mary L. Holston
(Address) 4019 Roland Ave

15 Filed MAY 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924. to May 13. 1927.

that I last saw her alive on May 13. 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 5 mos 20 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Path. exam. of tissues

(Signed) C. H. Jones, M. D.

5/13, 1927 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL May 16 1927

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Rd.

Please write plainly. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22246

CERTIFICATE OF DEATH.

23 E 22246

REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 13 WARD)

2-FULL NAME Mrs Anna. Hodnick.

(a) RESIDENCE No. 629 S. Belnard. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland-

PARENTS

10 NAME OF FATHER Anthony Jilski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wm Casimier Hodnicki son

(Address) 6291 Belnard ave

15 Filed 1927 C. HAMPTON JONES, M. D. Registrar

By R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4th. 1927, to May 13 1927, that I last saw her alive on May 13 1927, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis. (Lethargic?).

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical-

(Signed) Frank R. DiPaula, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cem

DATE OF BURIAL May 16 1927

20 UNDERTAKER John H Weber

ADDRESS 1803 Bank st

Spec.—12-9-25—A Co.—200 Bks.

Donoghue

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 289 6 E22247 — CERTIFICATE OF DEATH. — + 90 E 22247

1-PLACE OF DEATH — REGISTERED NO.

JOHNS HOPKINS HOSPI

City of BALTIMORE: (No. ____ St. 1-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Preston S- Donoghue

(a) RESIDENCE NO. Ruby - S- Car - St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 3 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rebecca

6 DATE OF BIRTH (month, day, and year) confirmed

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) South Car -

(State or country)

PARENTS

10 NAME OF FATHER Morgan Donoghue

11 BIRTHPLACE OF FATHER (city or town) S. Car -

(State or country)

12 MAIDEN NAME OF MOTHER Laura Price

13 BIRTHPLACE OF MOTHER (city or town) S. Car -

(State or country)

14 Informant Rena S -

(Address) JOHNS HOPKINS HO

15 Filed MAY 15 1927 C. HAMPSON JONES, M. D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 13, 1927, that I last saw h... alive on May 13, 1927, and that death occurred, on the date stated above, at 5 30 m.

The CAUSE OF DEATH* was as follows: Coronary sclerosis; hypocardia

(duration) ....yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cherow S. C. — Date of Burial 5/15/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec.—1-10-21 M&T 1500 Bks.

22248.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22248
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

57

E 22248
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 372 E. Clement St 24-33 WARD

2-FULL NAME Frank E. Bowman

(a) RESIDENCE No. 372 E. Clement ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Bowman

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
62	62	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Mary J. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Philip Bowman
(Address) 372 E. Clement St.

15 Filed MAY 15 1927 C. HAMPSON JONES, M. D. Registrar
By R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from August, 1926, to May 13, 1927, that I last saw her alive on May 13, 1927, and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Hammer, M. D.

, 19 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: May 16 1927

20 UNDERTAKER: Margaret E. Flynn ADDRESS: 1412 N. Fulton Ave.

Spec.—12-9-25—A Co.—200 Bks.

22249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22249

CERTIFICATE OF DEATH.

E 22249

90

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 Gorsuch Ave 9-46 Ward)

2-FULL NAME Mary A. Welch.

(a) RESIDENCE NO. 701 Gorsuch Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Welch.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Thos. Sudden

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ire.

12 MAIDEN NAME OF MOTHER Margaret Hour

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ire.

14 Informant Mary L. Connolly

(Address) 701 Gorsuch Ave

15 Filed MAY 15 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 13- 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1926, to May 13, 1927.

that I last saw h— alive on May 13, 1927.

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis,

mitral regurgitation and arterio sclerosis of heart.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! — Date of

Was there an autopsy! —

What test confirmed diagnosis! —

(Signed) K. J. Sheubrooks, M. D.

May 13 1927 (Address) 652 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Petersville Franc Md & Co May 16 1927

20 UNDERTAKER ADDRESS

Margaret G. Slyman, 422 Light St.

Cor.—12-9-25—A Co.—200 Bks.

Kaun.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22250

CERTIFICATE OF DEATH.

E 22250

REGISTERED NO. 24001

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Kaun

(a) RESIDENCE NO. 2530 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Kaun

6 DATE OF BIRTH (month, day, and year) Jan 6-1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Arnold Co 13

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Albert Kaun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elsie C. Kaun

(Address) 2530 W. Franklin St.

15 Filed May 16 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage 1/2 hr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 12, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial May 16 1927

20 UNDERTAKER George L. Schwab ADDRESS 2101 Fulton Ave.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22251

CERTIFICATE OF DEATH.

1125 129 E 22251

1-PLACE OF DEATH Hotel Sherwood

CITY OF BALTIMORE: (No. West Monument ST WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Key Blunt.

(a) RESIDENCE NO. Hotel Sherwood ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	79	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Simon Franz Blunt- U.S.N

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Ellen Lloyd Key

13 BIRTHPLACE OF MOTHER (city or town) Georgetown (State or country) D.C.

14 Informant Miss Mary Howard (Address) 701 St. Paul St.

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1927, to May 13th, 1927, that I last saw her alive on May 13th, 1927, and that death occurred, on the date stated above, at 5 15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremic Amaurosis (1 month.)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. Chatard, M. D.

May 14, 1927 (Address) 300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Frederick Md. DATE OF BURIAL: May 16 1927

UNDERTAKER: Henry H. Erwin's Sons Co ADDRESS: McCulloh & Orleans Sts.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22252

CERTIFICATE OF DEATH.

49 E 22252

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOS. St. 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Burley

(a) RESIDENCE NO. Cedar Hill Brooklyn - Md - St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colred

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3-5-18

7 AGE: Years 4 Months 2 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md -

(State or country)

PARENTS

10 NAME OF FATHER Casin Burley

11 BIRTHPLACE OF FATHER (city or town): Md -

(State or country)

12 MAIDEN NAME OF MOTHER Mate Langford

13 BIRTHPLACE OF MOTHER (city or town): N-C -

(State or country)

14 Informant: Friends -

(Address) JOHNS HOPKINS HOS.

15 Filed MAY 16 1927 E. HAMPSON JONES, M. D. Registrar

by R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May - 17, 1927, to May 18, 1927, that I last saw him alive on May 18, 1927, and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Bilateral kidney sarcoma with widespread metastases

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brooklyn, Md.

Did an operation precede death? — Date of

Was there an autopsy? Yes -

What test confirmed diagnosis?

(Signed) Thomas W. Cornell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvery — Date of Burial: May 16 19 27

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hanover Street

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22253

E 22253

CERTIFICATE OF DEATH.

REGISTERED NO. 162 W

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin & Radecke Ave. ST. 16-42 WARD Raspeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman George Christ

(a) RESIDENCE NO. Franklin & Radecke Ave. ST. WARD Raspeburg

(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14th 1927

7 AGE: Years — Months — Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles W. Christ

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine E. Lutz

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant Charles W. Christ (Address) Raspeburg Md.

15 Filed May 16 1927 Registrar C. HOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 1927, to May 15th, 1927, that I last saw h[illegible] alive on May 15th, 1927, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Jones, M. D.

May 15, 1927 (Address) 1501 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cmetery — DATE OF BURIAL: May 16 1927

20 UNDERTAKER: Frederick Bernard Sons — ADDRESS: Fulberton

Spec.–7-17-26—A Co.—200 Bks.

22254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128

E 22254

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 508 W Preston St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Hayes

(a) RESIDENCE NO. 508 W Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant William Hayes

(Address) 508 W Preston St

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

Plat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6 1927 to May 14 1927

that I last saw her alive on May 14 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm C. Wagner M. D.

5/16 1927 (Address) 706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial May 16 1927

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pine

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22255

CERTIFICATE OF DEATH.

8 E 22255

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1032 N. Gay St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Grace Klein

(a) RESIDENCE NO. 1032 N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) June 22-1920.

7 AGE: Years 6 | Months 10 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry C. Klein

11 BIRTHPLACE OF FATHER (city or town) Heilbron

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Lena Herold

13 BIRTHPLACE OF MOTHER (city or town) Ohnhausen

(State or country) Germany.

14 Informant Henry C. Klein

(Address) 1032 N. Gay St.

15 Filed MAY 16 1927 19

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-1927

17 I HEREBY CERTIFY, That I attended deceased from 5-11-, 1927, to 5-14, 1927, that I last saw h[illegible] alive on 5-14, 1927, and that death occurred, on the date stated above, at 11:55 a. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

5-15-1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Md. Date of Burial 1927.

20 UNDERTAKER: Geo. Leimbach ADDRESS 525 N. Gay St.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22256

CERTIFICATE OF DEATH

44

E 22256

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 632 S Monroe St. St. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Gilbert,

(a) RESIDENCE NO. 632 S Monroe St., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia (nee Murawski)

6 DATE OF BIRTH (month, day, and year)
March 6, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vulcanizing Auto Tires

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Pa.

PARENTS

10 NAME OF FATHER John Gilbert

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Leipe

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant A. W. Gilbert,
(Address) 632 S Monroe St.

15 Filed MAY 16 1927, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926, to May 13, 1927,
that I last saw h— alive on May 13, 1927,
and that death occurred, on the data stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma
Stomach

(duration) ..... yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Contributory Cachexia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted ——

If not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) [illegible] M. D.
5/14, 1927 (Address) 1729 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial 5/16/27 19

20 UNDERTAKER Harry A. Leitzke — ADDRESS 531 N Lanvale St

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22257

CERTIFICATE OF DEATH.

E 22257

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: Baltimore and Payson Sts

City of BALTIMORE: (No.) German Aged Home St. 30-27 Ward)

2-FULL NAME Sidonia Lauf.

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Lauf.

6 DATE OF BIRTH (month, day, and year): Nov 19 1852

7 AGE: Years 74 | Months 5 | Days 25 27 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Johann Gret.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Maria Deichert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Records German Aged Home Balto and Payson Sts

15 Filed....., 19 Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 27

17 I HEREBY CERTIFY That I attended deceased from 5/9/27, 19, to 9/14/27, 19, that I last saw h alive on 9/13/27 19, and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Douff, M. D.

, 19 (Address) 1843 N. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Clem Date of Burial May. 16 1927

20 UNDERTAKER: Joseph B Cook ADDRESS 1003 N. Balto St

MAY 16 1927

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22258

CERTIFICATE OF DEATH.

74-681

E 22258

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 S. Clinton ST. 76-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wilson

(a) RESIDENCE NO. 1020 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah

6 DATE OF BIRTH (month, day, and year) Aug. 24-1850

7 AGE	Years	Months	Days 19	If LESS than 1 day, hrs. or min.
	76	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Carl Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Christina Pretenda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs. Nellie Golden

(Address) 400 S Robinson St

15 Filed 19 Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11th. 1927, to May 13th. 1927, that I last saw him alive on May 13th. 1927 and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Jones, M. D.

5/14/1927 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 17 1927

20 UNDERTAKER George W. Zickler

ADDRESS 1739 E. Eager St.

MAY 16 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22259

CERTIFICATE OF DEATH.

90 E 22259

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1241 Riverside Ave. St. 04 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Raynor.

(a) RESIDENCE NO. 1241 Riverside Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Lena Raynor.

6 DATE OF BIRTH (month, day, and year) November 14, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Raynor.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Susanna Harvey.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Lena Raynor. (wife)

(Address) 1241 Riverside Ave.

15 FILED 1927 G. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto R. Reinhardt M. D.

(Coroner)

5/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial May 17 1927

20 UNDERTAKER H. Howard Evans ADDRESS 38 E. Fort Ave.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22260

CERTIFICATE OF DEATH.

18 E 22260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier 1 Bradt St. ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Sedgwick

(a) RESIDENCE No. 136 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Sedgwick

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deck Hand on
(b) General nature of industry, business or establishment in which employed (or employer) Steamer Virginia
(c) Name of employer Ches. & Ohio R. R. Co.

9 BIRTHPLACE (city or town) York Co. Va.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Sedgwick

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Roy

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mable Williams
(Address) 936 N. Gilmore St.

15 Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
fell off (or man) dock - Steamer Va.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Deadly
(duration) yrs. mos. ds.

(Signed) W. J. Fahey, M. D.
(Coroner.)
May 12, 192 7 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cemetery	May 16 1927

20 UNDERTAKER Chas. H. Johnson ADDRESS 446 N. Caroline St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22261

CERTIFICATE OF DEATH.

E 22261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Zeiler CHARLES G. ZEILER

(a) RESIDENCE NO. 700 S. 3rd ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine E. Zeiler

6 DATE OF BIRTH (month, day, and year) March 6th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) Lilly & Zeiler.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John G. Zeiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Catharine Dietzel

13 BIRTHPLACE OF MOTHER (city or town) " " Baltimore Md

14 Informant Catharine E. Zeiler. (Address) 700 S. 3rd St.

15 Filed MAY 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to May 13, 1927, that I last saw him alive on May 13, 1927, and that death occurred, on the date stated above, at 9 7 m.

The CAUSE OF DEATH* was as follows:

Anemia resulting from hemorrhage from stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. P. McDaniel, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL May 17 1927

UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Woods

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22262

CERTIFICATE OF DEATH.

12 E 22262

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Aliceana ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Kaster

(a) RESIDENCE No. 100 S. Highland Ave ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Nicholas Kaster

6 DATE OF BIRTH (month, day, and year) Feb. 13th 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER Frauds Yaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary.

12 MAIDEN NAME OF MOTHER Katharine Lieb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Nicholas Kaster

(Address) 100 S. Highland ave.

15 Filed MAY 16 1927 HAMPSON JONES, M. D. Registrar

Plat RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8th, 1927, to May 15th, 1927, that I last saw her alive on May 15th, 1927, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Sub diaphragmatic abscess.

Chr. Myocarditis & nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 5/12/27

Was there an autopsy? None.

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Thorne, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May 17th 1927

20 UNDERTAKER Lilly & Zeiler.

ADDRESS 1033 W. Lexington St

Spec.—12 9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 E 22263

CERTIFICATE OF DEATH.

31 V E 22263

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL S. 27-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Martin

(a) RESIDENCE NO. 614 Arlington Ave. St. Govanstown Md.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Martin

6 DATE OF BIRTH (month, day, and year) June 9, 1888 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New York City
(State or country)

PARENTS

10 NAME OF FATHER Orville Gilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Indianna

12 MAIDEN NAME OF MOTHER Miriam Mabee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Records
(Address JOHNS HOPKINS HOSPITAL)

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 15, 19 27 to May 14, 1927, that I last saw h alive on May 14, 1927, and that death occurred, on the date stated above, at 11.55 p m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Bacteriological

(Signed) E. Cowles Andrews, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Govanstown Date of Burial 5/17 1927

20 UNDERTAKER Elon Cook ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

Dr Campbell, 1644 Hanover St

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22264

CERTIFICATE OF DEATH

E 22264

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 38 Poultney St. 23-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa F Jones

(a) RESIDENCE NO. 38 Poultney St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Jones

6 DATE OF BIRTH (month, day, and year) Oct 28 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER William Cummings

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Kemp

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Milton G Jones

(Address) 1381 Hollins St

15 Filed MAY 16 1927 16 C. HAMPSON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927 to May 13, 1927

that I last saw h alive on May 13, 1927

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell M. D.

May 13, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial May 16 1927

20 UNDERTAKER H. Cook ADDRESS 607 E Baltimore

Very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 22265 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED E 22265

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4006 Penhurst Ave ST. 15-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Nellie A. Johnson

(Residence in Baltimore: No. 4006 Penhurst Ave. St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWER OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, February 20th, 1858 (Month) (Day) (Year)

7-AGE, 69 yrs. 2 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Timothy Herrington

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Martha Gifford

13-BIRTHPLACE OF MOTHER (State or Country), Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter G. Johnson

(Address) 3404 Sheffield Ave

15-

Filed ..... 191.....

Registrar.

MAY 16 1927 H. MARRON, M.D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from — — 1925, to May 13 1927, that I saw her alive on May 13 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis Hypertension

Cardiac Insufficiency Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilitation.

(Duration), yrs. mos. 1 ds.

(Signed) Howard [illegible] M. D.

May 13, 1927 (Address) 2607 Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, May 16, 1927

20-UNDERTAKER Smith & Dickey Inc — ADDRESS 2 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22266

CERTIFICATE OF DEATH.

129 E 22266

E 22266
1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 2054 Kennedy ST. 9-46 WARD)

2-FULL NAME William E Murray.

(a) RESIDENCE No 2054 Kennedy ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 10 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah E. Murray.

6 DATE OF BIRTH (month, day, and year) May. 18 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gate Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Cemetery
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delware. Md.

PARENTS

10 NAME OF FATHER William. E Murray.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.
12 MAIDEN NAME OF MOTHER Mary. Ann Murray.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Sarah E Murray.
(Address) 2054 Kennedy ave. M.

15 Filed MAY 16 1927 C. HAMPSON JONES, M. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to May 12, 1927,
that I last saw him alive on May 12, 1927
and that death occurred, on the date stated above, at 8.05 P m
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Arteriosclerosis

(duration) 15 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chr. Interstit Nephritis
(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical Examination
(Signed) Thos. P. Geraghty, M. D.
5/15, 1927 (Address) 2225 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	May 16 1927
20 UNDERTAKER	ADDRESS
Geo. F. Ruth.	1735 Harford Av.

Spec.—12-9-25—A Co.—200 Bks.

E 22267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001

E 22267

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Collison

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Collison

6 DATE OF BIRTH (month, day, and year): Aug 10th 1861

7 AGE: Years 66 (65) | Months 9 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Hilaire Roland

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Delia Henry

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Little Sisters of the Poor

(Address): Preston & Valley St

15 Filed ..... 19.....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from My record ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Ramer, M. D.

5/12, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — Date of Burial: 5/17 1927

20 UNDERTAKER: George J Ruth — ADDRESS: 1755 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22268

E 22268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Costa Manganolis

(a) RESIDENCE NO. 1718 Thames Street ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 10 mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8- 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer S/S Howard

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Jim Manganolis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records
(Address) 1718 Thames st

15 Filed MAY 16 1927, 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1926, to May 15, 1927.

that I last saw h[illegible] alive on May 15, 1927.

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Estimated (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & Laboratory tests

(Signed) W. W. Benton M. D.
Asst Surgeon U. S. P. H. S.
5-15, 1927 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wood Lawn Cemetery

DATE OF BURIAL: May 17 1927

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1735 Harford Ave

Spec.—1-10-21 M&T 1500 Bks.

E 22269

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

E 22269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5601 Govane Ave St. Govane 27-48 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Norris Barbour

(a) RESIDENCE No. 5601 Govane Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	43	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mountied 87

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry L. Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Supp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Howard Barbour

(Address) 5312 Oakland Ave

15 Filed 1 6 1927 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 13, 1927, that I last saw h alive on May 13, 1927, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Solar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. LeRoy Wright, M. D.

, 19 (Address) 14 Sherwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/16/1927

20 UNDERTAKER Geo. Weber & Son 2503 Edmondson Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22270

CERTIFICATE OF DEATH.

57

E 22270

REGISTERED NO. 2756

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5112 Wilson St. (St.) (Ward)

2-FULL NAME Regina Sacks,

(a) RESIDENCE NO. 5112 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Sacks

6 DATE OF BIRTH (month, day, and year) August 8, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	57	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Riga. Russia

PARENTS

10 NAME OF FATHER Joseph Odelsky

11 BIRTHPLACE OF FATHER (city or town) Riga (State or country) Russia

12 MAIDEN NAME OF MOTHER Regina Odelsky

13 BIRTHPLACE OF MOTHER (city or town) Riga (State or country) Russia

14 Informant Isaac M. Sacks

(Address) 5112 Wilson St.

15 Filed MAY 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to Present, 19..., that I last saw her alive on May 14, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

of uncertain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

Arteriosclerosis (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stranes, M. D.

, 19 (Address) 1201 Griffis Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship DATE OF BURIAL 5/16 1927

20 UNDERTAKER York Sinai ADDRESS 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22271

CERTIFICATE OF DEATH.

57 E 22271

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1804 N Smallwood ST. 15-6X WARD)

2-FULL NAME Nora Pierson

(a) RESIDENCE NO. 1804 N Smallwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Pierson

6 DATE OF BIRTH (month, day, and year) Oct 14 71

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Morris Pierson
(Address) 1804 Smallwood

15 Filed MAY 16 1927 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1927, to May 14th, 1927, that I last saw her alive on May 14th, 1927 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene of foot 1926
Diabetic Coma (duration) yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. A. Waldran, M. D.

, 19 (Address) 210 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 17 1927
20 UNDERTAKER	ADDRESS
H. W. Coulson	2230 N Avenue

REGULATIONS ON BACK OF CERTIFICATE.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22272

38 E 22272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at 12-30

City of BALTIMORE: (No. Balt City Hospl St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Hinson

(a) RESIDENCE NO. 106 W Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1890

7 AGE: About 37 Years 32 Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Bessie Walton

(Address) 106 W Conway

15 Filed May 16 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Due to Injected Leg.

(duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

5/16, 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Bur Date of Burial: May 16 1927

20 UNDERTAKER: W McCourtson ADDRESS 2238 W Balto

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 22273 REGISTERED NO.

EPI 22273 DEATH

City of BALTIMORE: (No. 1638 E. Madison St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Berry

(a) RESIDENCE NO. 1638 E. Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Danville, (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lula Berry

(Address) 1638 E. Monument

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9 1927, to May 12, 1927, that I last saw h.. alive on May 12, 1927, and that death occurred, on the date stated above, at 10-45 m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Phthisis

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms Post Mortem Hospital

(Signed) J. Edward Fisher M. D.

5-12, 1927 (Address) 1612 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial May 16 1927

20 UNDERTAKER Edward Bryan ADDRESS 631 Orleans st

Spec.-7-17-26—A Co.—200 Bks.

B 22274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 E 22274

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals (6-10) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matt Anderson

(a) RESIDENCE NO. 204 N. Montford ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Anderson

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Jack Anderson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Thaniel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address)

Filed MAY 16 1927 19 Per C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927 to May 14, 1927 19

that I last saw him alive on May 14, 1927 19

and that death occurred, on the data stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gatteus M. D.

5-14-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

Date of Burial May 17 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22275 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22275

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 E. Balto. ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Wriner

(a) RESIDENCE NO. 1444 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male ~~White~~

4 COLOR OR RACE White ~~Married~~

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Wriner

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Parsty Wriner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E Balto St

Filed MAY 16 1927 Registrar C. HAMPSON JONES, M. D.

Per Howard

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15- 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to May 15 1927,

that I last saw living on " 4 1927

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) G. F. Ries M. D.

May 16, 1927 (Address) 24 E Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North Point German Hill Rd DATE OF BURIAL 5-16-1927

UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

ATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Unwood & Catherine

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22276

CERTIFICATE OF DEATH.

E 22276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (Johns Hopkins Hospital St., 19-27 Ward)

2-FULL NAME Unwood Catherine

(a) RESIDENCE NO. 1523 N. Sexuphi St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-17-24

7 AGE: Years 2 yrs. Months 6 Days 29. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Catherine

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Elsie Ogris

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

By H. A. Doe

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 14, 1927, that I last saw him alive on May 14, 1927, and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. O'Brien, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — Date of Burial 5-16 1927

20 UNDERTAKER: Joseph A. Sivley — ADDRESS 4092 Monument

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22277

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22277

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1435 Argyle St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Whatley

(a) Residence No. 1435 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 19 1869

7-AGE 58 yrs. 25 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Lizzie Smith

(Address) 1435 Argyle St

15- Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14. 1927

I HEREBY CERTIFY, That I attended deceased from April 12 1927 to May 13 1927 that I last saw h- alive on May 13 1927 and that death occurred, on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Undetermined

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex-

(Signed) D. Garland Hyatt M.D.

May 14 1927 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Zion

DATE OF BURIAL. 5-18- 1927

20-UNDERTAKER. Joseph A. Lively

ADDRESS 409 N. Mount St

Spec.-7-17-26—A Co.—200 Bks.

E 22278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 22278

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5015 Tioga Ave. Ge[illegible] 27-78 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Beauchamp

(a) RESIDENCE NO. 5015 Tioga Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Beauchamp

6 DATE OF BIRTH (month, day, and year) Mar. 21, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Windsor,

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Fishpaw

11 BIRTHPLACE OF FATHER (City or town) New Windsor

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Hibbert

13 BIRTHPLACE OF MOTHER (city or town) New Windsor

(State or country) Md.

14 Informant Charles Beauchamp

(Address) 5015 Tioga Ave.

15 Filed MAY 16 1927 19 C. LEMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 14, 1927,

that I last saw h[illegible] alive on May 13, 1927

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Lvs. Nephritis,

Chr. Myocarditis

Mitral & Aortic Insufficiency.

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted Yes

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. K. Bishop, M. D.

May 14, 1927 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cedar Hill Cemetery	May 17 1927
20 UNDERTAKER	ADDRESS
J. John F. Denny	715 Light St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22279

CERTIFICATE OF DEATH.

90 E 22279

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 St Paul ST. 11-15 WARD)

2-FULL NAME William Woolsey Johnson

(a) RESIDENCE NO. 909 St. Paul ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ ~~WIFE of~~ Susannah Leverett Batcheller

6 DATE OF BIRTH (month, day, and year) June 23, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor of Mathematics, U.S. Navy, retired

(b) General nature of industry, business, or establishment in which employed (or employer) teaching

(c) Name of employer U.S. Naval Academy, U.S. Navy

9 BIRTHPLACE (city or town) Tioga County
(State or country) New York

PARENTS

10 NAME OF FATHER Charles Frederick Johnson

11 BIRTHPLACE OF FATHER (city or town) Stratford
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Sarah Dwight Woolsey

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country) N.Y.

14 Informant Charles W. Johnson
(Address) 909 St. Paul St.

15 Filed MAY 16 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1927, to May 14th, 1927, that I last saw him alive on May 14th, 1927, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Disease

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Bloomfield, M. D.

, 19 (Address) 24 N. Liddazd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 5-17 1927

20 UNDERTAKER Geo. W. Huntemann & Son Co.

ADDRESS Orchard & McCulloh

Carlos. Hancock.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22280

CERTIFICATE OF DEATH

31 E 22280

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospital St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlos Hancock

(a) RESIDENCE NO. 423 N. Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Nellie Hancock

6 DATE OF BIRTH (month, day, and year) 8-28-1869

7 AGE: 57 Years 8 Months 17 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Spain

PARENTS

10 NAME OF FATHER Arlon Hancock

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Fannie Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant: Hospital Records

(Address)

15 Filed 19

Registrar

C. HAMPSON JONES M. D.

MAY 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

May 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1927, to May 15th, 1927,

that I last saw him alive on May 2nd, 1927,

and that death occurred, on the date stated above, at 9.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gatchell M. D.

5-14-1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: May 16 1927

20 UNDERTAKER: Robt J Turner & Bro — ADDRESS: [illegible] Broadway

Very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22281

CERTIFICATE OF DEATH

90

E 22281

1-PLACE OF DEATH

Original

City of BALTIMORE: (No. 328 Augusta Ave St. 70-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphens H. Pulley

(a) RESIDENCE NO. 328 Augusta Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Pulley

6 DATE OF BIRTH (month, day, and year): Feb. 8. 1853

7 AGE — Years: 74 — Months: 3 — Days: 6 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Marble Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 4 years

(c) Name of employer

076

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Pulley

11 BIRTHPLACE OF FATHER (City or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. L. L. Waldschmidt

(Address) 328 Augusta Ave

15 Filed MAY 16 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1927, to May 14, 1927, that I last saw h.. alive on May 14, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Virginia Pectoris

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Alphens H. Pulley, M. D.

5/16. 1927 (Address) 220 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: May 17 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

THOMPSON JONES, M. D.

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22282

CERTIFICATE OF DEATH.

+ 90 E 22282

1-PLACE OF DEATH

CITY OF BALTIMORE—No. U. S. Marine Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson E. Ackerly

(a) RESIDENCE NO. Frankfort, Indiana ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 20, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wireless Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Federal Service

9 BIRTHPLACE (city or town) (State or country) Frankfort Indiana

PARENTS

10 NAME OF FATHER Emery E. Ackerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Jennie Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Records

(Address)

15 Filed ....., 19 .... Registrar

C. HAMPSON JONES, M. D.

MAY 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 16, 1927, that I last saw h[illegible] alive on May 16, 1927, and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Combined lesions

Approximate (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical findings and Laboratory tests

(Signed) W. W. Benton M. D.

5-16, 1927 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frankfort Ind.

DATE OF BURIAL May 16 1927

20 UNDERTAKER E. Roy Steffen

ADDRESS 125 North ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22283

CERTIFICATE OF DEATH.

E 22283

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2114 (Street) Maryland ave (Ward) 17-51

2-FULL NAME Frank E. Ware

(a) RESIDENCE NO. 2114 Maryland ST., ward 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Marrid

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Flora Ware

6 DATE OF BIRTH (month, day, and year): Feb 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Main

10 NAME OF FATHER: Wm Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

Informant: Flora Ware

(Address) 2114 Md ave

Filed MAY 6 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Mussleman, M. D. (Coroner)

5/6, 1927 (Address) 2312 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waterville Maine

DATE OF BURIAL: May 16 1927

20 UNDERTAKER: E. L. Roy Stiffler

ADDRESS: 12 E North ave

Spec.—1-10-21—M&T—1500 Bks.

22284 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22284

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S Linwood St. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dickerson

(a) RESIDENCE NO. 713 S Linwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Corrie Dickerson

6 DATE OF BIRTH (month, day and year) Jan 23 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Dickerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Catherine Ulrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Corrie Dickerson

(Address) 713 S Linwood

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1927, to May 14, 1927

That I last saw her alive on May 14, 1927

and that death occurred, on the date stated above, at 11 AM

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William J. Brandt M.D.

(Address) 701 E Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: May 17 1927

UNDERTAKER: George A. Weber ADDRESS: 2205 Bank St

Spec.–7-17-26—A Co.—200 Bks.

E 22285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 22285

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 911 Sterling St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Myrick

(a) RESIDENCE NO. 911 Sterling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jessey Myrick

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 33 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): V. a

PARENTS

10 NAME OF FATHER: Sam Myrick

11 BIRTHPLACE OF FATHER (City or town) (State or country): V. a

12 MAIDEN NAME OF MOTHER: Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): V. a

14 Informant: James Duglass

(Address): 911 Sterling st

15 Filed 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/14/1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 13, 1927

that I last saw him alive on May 13, 1927

and that death occurred, on the data stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Cold (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no What test confirmed diagnosis? medical

(Signed) J. Walters M. D.

. 19 (Address) 1635 M E Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jarratt. Va — Date of Burial: may 17 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1651 orleans st

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22286 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladislaw (Harry) Kupidlowski (alias Busch)

(a) RESIDENCE NO. 626 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Michalina Kupidlowski

6 DATE OF BIRTH (month, day, and year) Out. Univ Hosp 1880

7 AGE: Years 47 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Betty ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Lena Kupidlowski (Address) 620 S. Washington St.

15 Filed MAY 16 1927, 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13. 1927.

17 I HEREBY CERTIFY, That I attended deceased from 5/11/27, 19, to 5/13/27, 19, that I last saw h/ alive on 5/13/27, 19, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia at the Right Base

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) J. L. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: May 17 1927

UNDERTAKER: F. N. Ozazewski — ADDRESS: 1930 Eastern Av.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22287

CERTIFICATE OF DEATH.

129

E 22287

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 838 S Bond St., 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Przybyszz

(a) RESIDENCE NO. 838 S Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	whit	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Przybyszz

6 DATE OF BIRTH (month, day, and year) March 8 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Common

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Przybyszz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mary Przybyszz

(Address) 1931 Fort Ave

HAMPSON JONES, M. D.

Filed MAY 16 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Dilated heart (duration) yrs. 6 mos. ds.

(Signed) James M Hinton M. D.

(Coroner)

May 15 1927 (Address) 700 Chase

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus em Date of Burial: May 17 1927

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22288

CERTIFICATE OF DEATH.

90

E 22288

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 733 W Cross St. Ward 21-24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Roman

(a) RESIDENCE NO. 733 W Cross St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Roman

6 DATE OF BIRTH (month, day, and year): ~~Feb~~ 16 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto

PARENTS

10 NAME OF FATHER Henry Harrison

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto

12 MAIDEN NAME OF MOTHER Dant Knod

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto

14 Informant Henry Roman

(Address) 733 W Cross St

Filed MAY 16 1927

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/27

17 I HEREBY CERTIFY, That I attended deceased from 4/14/27, to 5/14/27,

that I last saw h.. alive on 5/14/27,

and that death occurred, on the date stated above, at 9:55 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Mitral Regurg.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Signs

(Signed) Bernard J. Tenny, M. D.

5/15/27 (Address) 915 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: May 17 1927

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W Fayette

Spec.—I-10-21—M&T—1500 Bks.

Jarasevicius ✓

E 22289 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-201 E 22289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 531 W Barre ST. 22-30 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jarasevicius

(a) RESIDENCE NO. 531 W Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Jarasevicius

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE — Years: In definite age. 56 yrs. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Garment worker

(b) General nature of industry, business, or establishment in which employed (or employer): ore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Joseph Jarasevicius Son (Address) 531 W Barre St.

15 Filed MAY 16 1927 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to May 15, 1927, that I last saw him alive on May 15, 1927, and that death occurred, on the date stated above, at 2.35 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M. G. Spilsinger M. D.

5/16, 1927 (Address) 682 Whitelock Blvd —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL 5/19/27

20 UNDERTAKER: Chas. H. Zachmanoglou — ADDRESS 637 Cead

Spec.—12-9-25—A Co.—209 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22290
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

+71-001 V

E 22290
REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Davis

(a) RESIDENCE NO. Jonestown Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1926.

7 AGE: Years 10 Months 10 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Frank R. Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Gladys Hans

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

14 Informant Reads
(Address) JOHNS HOPKINS HOSPITAL

15 FILED APR 6 1927 C. HAMPSON JONES, M. D. Registrar Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927, to May 15, 1927, that I last saw him alive on May 15, 1927, and that death occurred, on the date stated above, at 6:05 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis, pneumococcal
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Lumbar puncture
(Signed) J. P. Price, M. D.
, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington, Md. Date of Burial May 17, 27

20 UNDERTAKER H. S. Bailey ADDRESS Darlington, Md.

Cor.—12-9-25—A Co.—200 Bks.

E 22291

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22291

CERTIFICATE OF DEATH.

100-21

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 N. Carrison St. 17-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reuben Johnson

(a) RESIDENCE NO. 518 N. Carrison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer General

9 BIRTHPLACE (city or town).....
(State or country) Va

PARENTS

10 NAME OF FATHER Benj. Johnson

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Va

12 MAIDEN NAME OF MOTHER Tamma Bisby

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Va.

14 Informant Rebecca Brice
(Address) 518 N. Carrison St

15 Filed 6 1927 16 C. HAMPSON JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Kenney M. D.
(Coroner)

192 7 (Address) 2802 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cemetery — May 16, 1927

20 UNDERTAKER — ADDRESS

Mrs Katie R Williams — 322 S Schroeder St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22292

CERTIFICATE OF DEATH.

E 22292

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 746 W. Lexington ST. 4 (WARD)

2-FULL NAME Charlotte Bussenius

(a) RESIDENCE NO. 746 W. Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) May 28, 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Rowald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Sander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theodore W. Esterkamp

(Address) 746 W. Lexington St.

15 Filed May 16, 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to May 14, 1927, that I last saw her alive on May 13, 1927, and that death occurred, on the date stated above, at 6 05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) old age

(duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Thos D Hemmeter, M. D.

May 16, 1927 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 5/17 1927

20 UNDERTAKER Louis Heemann

ADDRESS 3128 Bway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22293 E 22293

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2108 N. Saratoga St. (Ward) 20-69

2-FULL NAME Annie C. Droney

(a) RESIDENCE NO. 2108 N. Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18th 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Texas

PARENTS

10 NAME OF FATHER John McDermott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Sullivan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Winifred Stanley

(Address) 27 N. Eutaw St.

15 Filed 1927 19

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 13th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

Inquiry find that said deceased came to her death as stated below, to wit: (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) At once yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

May 14th 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Texas Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 5/17/27

20 UNDERTAKER Martin Fahey Sons ADDRESS 5th & State

Spec.—12-9-25—A Co.—200 Bks.

E 22294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-003 E 22294

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Roles

(a) RESIDENCE NO. 826 Sterling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar. 28, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town):

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Miles

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Clara Roles

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant:

(Address) JOHNS HOPKINS HOSPI

I hereby certify that I attended deceased from 1927 C. HAMPSON JONES, M. D.

Registrar

Per ARB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 2, 19 27, to May 14, 19 27, that I last saw h. alive on May 14, 19 27, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Pyloric stenosis

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Intracranial Hemorrhage

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of May 13.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation. Sumbarpuncture.

(Signed) J. O'Brien, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

Date of Burial: May 16 1927

20 UNDERTAKER: Mrs R A Elliott

ADDRESS: 1725 Archdale

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22295

CERTIFICATE OF DEATH.

90 E 22295

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospts

City of BALTIMORE: (No. Balto Md St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvator Merlino

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? Unknown

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
62				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): Peddler

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Italy

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Balto City Hospts

(Address): Balto Md

8 19 27 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-10-27

17

I HEREBY CERTIFY, That I attended deceased from 10-28, 1926 to 5-10, 1927.

that I last saw him alive on 5-10, 1927

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH was as follows:

Myocardial Insufficiency

Cardiac Hypertrophy +

Dilitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis, Paranoid Reaction Type

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) John Fedorchak M. D.

5/11/27. (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn Mem'l Date of Burial 5/16 19 27

20 UNDERTAKER: Jos. J. Garry & Sons ADDRESS 1310 Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

E 22296 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22296

Jacob B. Fahmer

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 8-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob B Fahmer

(a) RESIDENCE NO. 2034 E. Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Black-smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Fahmer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1927

17

I HEREBY CERTIFY, That I attended deceased from May 14 1927, to May 15 1927, that I last saw him alive on May 14, 1927, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and insufficiency

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? N.D. Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gennal & Laboratory

(Signed) R. Hooper Smith M. D.

May 16 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial May 17 1927

20 UNDERTAKER Henry Stock Son ADDRESS 1201 E Eager St

Spec.—1-10-21 M&T—1500 Bks.

E 22297

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22297

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Garrison Ave ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Wray McLean

(a) RESIDENCE NO. 3910 Garrison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ John W. McLean

6 DATE OF BIRTH (month, day, and year) Feb. 20 1847

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
80	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Philip H. Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Elizebath Trosper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant John W. McLean (Address) 3910 Garrison Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2nd. 1926 to May 14th. 1927.

that I last saw h[illegible] alive on May 14th. 1927.

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Poulton M. D.

May 15, 1927 (Address) 3909 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL 5/17 1927

20 UNDERTAKER Chas. E. Franch & Oscar J. Groff ADDRESS 902 Mondawmin Ave

Spec.—1-12-23—M&T—500 Bks.

E 22298

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22298

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 44 S. Poppleton ST. 18-24 (WARD)

2-FULL NAME Bertha M. Blair

(a) RESIDENCE NO. 44 S. Poppleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William P. Blair

6 DATE OF BIRTH (month, day, and year): Sept. 12, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Daniel Zimmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Woodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. Wm.P. Blair

(Address): 44 S. Poppleton St

15 Filed: 6 1927 G. HAMPSON JONES, M. D., Registrar

Per: R.K.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1926, to May 13, 1927, that I last saw her alive on May 13, 1927 and that death occurred, on the date stated above, at 6;30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ellen O'Donnell M. D.

5/16, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New. Cathedral Cemetery — DATE OF BURIAL: 5/17 '27

20 UNDERTAKER: John J. Cowen & Sons. — ADDRESS: 901 Hollin

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22299 — 58 — E 22299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital — REGISTERED NO. 18-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. Fayette & Calhoun Sts.) WARD

2-FULL NAME Mrs. Barbara Griebe

(a) RESIDENCE No. 101 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): September 1860

7 AGE: 67 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore and Md

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Barbara Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Griebe

(Address): 101 Hollins St

15 Filed: 6 1927 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12 .19 27 . to May 15 .19 27.

that I last saw h[illegible] alive on May 15 .19 27.

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) W Wallace Walker M. D.

.19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: May 19 1927

20 UNDERTAKER: John J Cowan & Son — ADDRESS: 901 Hollins St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22300 E 22300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. North Calvert St. ST., 4-7 WARD)

2-FULL NAME Mr. Anthony P. Harmon

(a) RESIDENCE NO. Nunnery Lane Catonsville Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary D. Harmon

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1867

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs or.....min.
	59	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Overseer of Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mt. De Sales Academy

9 BIRTHPLACE (city or town) (State or country) Catonsville, Md.

PARENTS

10 NAME OF FATHER Anthony Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mary C. Harmon

(Address) Nunnery Lane, Catonsville, Md.

15 Filed May 13, 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to May 13, 1927, that I last saw him alive on May 13, 1927, and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-11-27

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL May 17 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22301

CERTIFICATE OF DEATH.

118 E 22301

1-PLACE OF DEATH West Baltimore General Hospital

REGISTERED NO.

City of BALTIMORE: (No. Rayner & Dukeland Ave's. N-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Walter Donoghue

(a) RESIDENCE NO. 2301 Edmondson Ave., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 3, 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fidelity Trust Co.,

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James J. Donoghue

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Celia Stokes

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. Pauline Z. Shawker

(Address) 2301 Edmondson Ave.

15 Filed C. HAMPSON JONES, M. D.

1927 Ber RRB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 13, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

5/14 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Date of Burial May 17 1927

20 UNDERTAKER Joseph D Cook ADDRESS 1003 N. Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

E 22302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

198 E 22302

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Insanity Hosp. St. 4-30 Ward)

2-FULL NAME Joseph Boyter

(a) RESIDENCE NO._____ St._____ Ward_____
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	not known

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Asylum

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

Date 1927 C. HAMPSON JONES M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from stab wound upper part of thigh

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

, 19 27 (Address) 3328 Reed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

...—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22303

CERTIFICATE OF DEATH. 1927

E 22303

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Merchant & Mines Wharf or boat Ward)

2-FULL NAME W. C. Gilliard

(a) RESIDENCE NO. St. Helena Island S. C. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 26 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): St. Helena Island

(State or country) S. Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed May 25, 1927 HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to stab wound of chest Homicidal

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

(Coroner)

May 25, 1927 (Address) 1052 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial MAY 16 1927 19

20 UNDERTAKER ADDRESS

Commissioner of Health.

UNIVERSITY OF MARYLAND

56

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22304

CERTIFICATE OF DEATH.

66 E 22304

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp St. 4-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Taylor

(a) RESIDENCE NO. Not Known St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Not Given

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Not Given

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address)

15 Filed 19 [illegible] M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. E. Bruehl M. D.
(Coroner)

19 (Address) 332 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dolphyn Date of Burial June 15 25

20 UNDERTAKER C. E. Evans & Son ADDRESS 118 W. Fayette 19

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22305

CERTIFICATE OF DEATH.

173 E 22305

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No Name

(a) RESIDENCE NO. Not Known St. Ward

(Usual place of abode) (If not resident of city, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M[illegible]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
52				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 87

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 1927 C. HAMPSON JONES, M. D.

Registrar

1360

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 - 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Multiple fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

May 1927 (Signed) H C Jones M. D.

(Coroner)

(Address) 475 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health,

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22306

CERTIFICATE OF DEATH.

182 E 22306

1-PLACE OF DEATH

City of BALTIMORE: (No. Found floating in the water off Mexican Petroleum Co. Curtis Bay 0527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Unknown. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Body much decomposed. Do not know.

5 Single, Married, Widowed, or Divorced, (write the word): Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ---

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE: Years: about 85; Months: ---; Days: ---; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Do not know.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Do not know.

14 Informant: Police Report. S. D.

(Address)

15 Filed 6 1927 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Body found May 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably accidental Drowning.
Body very much decomposed.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. Reinhardt M. D.

(Coroner)

5/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. Date of Burial MAY 14 1927 19

20 UNDERTAKER ADDRESS

Commissioner of Health

Spec.—1-12-23—M&T—500 Blks.

E 22307.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-81

E 22307

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 16-22 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Bernadi

(a) RESIDENCE NO. 1124 N. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-14-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3 hours			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Earl Bernadi

11 BIRTHPLACE OF FATHER (city or town) (State or country) not given

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Earl Bernadi
(Address) 1124 N. Fulton Ave

15 Filed JUN 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

1362

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-14, 1927, to 5-14, 1927,

that I last saw her alive on 5-14, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(a) Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. K. McBride M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 15 1927, 19

20 UNDERTAKER

ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

E 22308

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22308

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth C. Lee

(a) RESIDENCE NO. 103 Linden Terrace St. Ward

(Usual place of abode) Towson, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 31, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Alabama

PARENTS

10 NAME OF FATHER R. H. Lee

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. C. Lee (Brother) (Address) Hartford, Conn.

Filed 6-1927, 19 RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1927, to May 15, 1927, that I last saw her alive on May 15, 1927, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Cerebral Thrombosis (Apl?)

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY Chronic Valvular Heart Disease.

(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frankel Smith, Jr. M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Arlington National Cem'y	May 18 1927
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son, Inc.	[illegible]

Very important. See instructions on back of certificates.

E 22309

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22309

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Brantly Ave St. 16-26 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Elizebetha Kennedy

(Residence in Baltimore: No. 1031 Brantly Ave St.; 79 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 10 (Day), 1847 (Year)

7-AGE. 80 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Wilmington Del

PARENTS.

10-NAME OF FATHER, John Cassidy

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), New York N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine R. Kennedy

(Address) 1031 Brantly St.

15-

Filed 6 1927

C. HAMPSON JONES, M. D.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5th 1927, to May 13th 1927, that I saw her alive on May 14th 1927, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

Subject of Arthritis deformans for several years

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bedridden for years

(Duration) yrs. mos. ds.

(Signed) W. F. Hill M. D.

5.16.27, 191.. (Address) 3711 Liberty Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1031 Brantley Ave Balto Md

19-PLACE OF BURIAL, OR REMOVAL. St Marys Cem Govans

DATE OF BURIAL, 5.17.27, 191..

20-UNDERTAKER Mary M. Widefeld

ADDRESS 501 E 21st St.

Spec.–7-17-26—A Co.—200 Bks.

Dr Dean 1227 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22310

CERTIFICATE OF DEATH

90 E 22310

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 119 St. Scott 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Harrell

(a) RESIDENCE NO. 119 St. Scott St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 29, 1874

7 AGE: Years 52 Months 10 Days 17

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Wm. Hammond Parker

9 BIRTHPLACE (city or town): Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER: John Harrell

11 BIRTHPLACE OF FATHER (City or town): Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town): Balto (State or country) Md

14 Informant: Mary Harrell (Address) 119 Scott St

15 Filed: JUN 6 1927 By RKH

16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to May 16, 1927

that I last saw h[illegible] alive on May 16, 1927

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dean, M. D.

, 19 (Address) 119 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: May 19 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 501 E. York

Key important. See instructions on back of certificate.

Spec'y—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22311

CERTIFICATE OF DEATH.

90 E 22311

REGISTERED NO.

1-PLACE OF DEATH Lunatic Hospital

City of BALTIMORE: (No. 1213 S Eutaw St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Clark

(a) RESIDENCE NO. 2 E Randall St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice L. Schaefer

6 DATE OF BIRTH (month, day, and year) Sept. 5th 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Penna

PARENTS

10 NAME OF FATHER Lem Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Harriet Birkett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Sallie Gabler

(Address) 1741 Covington St.

15 Filed C. HAMPSON JONES, M. D. Registrar

6 1927 By Roberts

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 11, 19 27, to May 15, 19 27

that I last saw h.. alive on May 14, 19 27

and that death occurred, on the date stated above, at 1:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Oedema of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. Miller, M. D.

19 (Address) Lunatic Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyndman, Pa. Date of Burial 5/17/27

20 UNDERTAKER E. J. Fanning Inc - 1460 ADDRESS Battery Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22312
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C 13537 90 E 22312

City of BALTIMORE: (No. Union Memorial Hosp St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer G Barrier

(Residence in Baltimore: No. 3535 Roland Ave St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Feb. (Month) 7 (Day) 1868 (Year)

7-AGE: 39 yrs. 3 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: D 23
(b) General nature of industry, business, or establishment in which employed (or employer): Chauffeur

9-BIRTHPLACE (State or Country): Balto Co.

PARENTS.

10-NAME OF FATHER: Wm H Barrier

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Harriet A Webb

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barrier

(Address) 3535 Roland Ave

15-
Filed MAY 17 1927 C. HAMPSON JONES, M. D.
Registrar.
By

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) 5/14 (Day) 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Aneurism of Aorta

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

5/16 192.7 (Address) 3522 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted. If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
St Mary's Hampden May 17 19 27

20-UNDERTAKER. ADDRESS.
D S Marshall 3539 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22313

CERTIFICATE OF DEATH.

129 E 22313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Lebena Ave ST.) Mt Wash 27-54 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susannah Dankoff

(a) RESIDENCE NO. 8 Lebena ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ (HUSBAND) of (or) WIFE of Wm E Dankoff

6 DATE OF BIRTH (month, day, and year) 5. 7. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Mellon 5.15. 1927 (Address) Mt Washington Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Martha Fry (Address) Mt Washington Md

15 Filed 1927 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 15. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 . 1927 . to May 15 . 1927 . that I last saw h alive on May 15 . 1927 . and that death occurred, on the date stated above, at 7. P m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Chronic Bright

Arteri Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General

(Signed) E. H. Beeten, M. D.

(Address) Mt Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cella County Cella DATE OF BURIAL May 18 1927

20 UNDERTAKER D S Marshall ADDRESS 3539 Falls Rd

Spec.—12-9-25—A Co.—200 Bks.

E 22314

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 22314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St., 19-28 Ward)

2-FULL NAME Anna Crook

(a) RESIDENCE NO. 404 S Eylmore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Frank Crook

6 DATE OF BIRTH (month, day, and year) 1853 Jan 28 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
93	74	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Bachelder Bixley

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant [illegible]

(Address) [illegible] Beech

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927, to May 14, 1927, that I last saw h[illegible] alive on May 14, 1927, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Thorpe Linell, M. D.

May 16 1927 (Address) [illegible]

*State the Disease Causing Death, or in Deaths From Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial 5/18/1927

20 UNDERTAKER Geo. Wilbert & Son ADDRESS 2503 Edmund

Spec.—1-12-23—M&T—500 Blks.

E 22315 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO. 21-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Mrs. Mabel W. Seim

(a) RESIDENCE No 1334 Sergeant ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Wm O Seim

6 DATE OF BIRTH (month, day, and year): August 28 1888

7 AGE — Years: 38 — Months: 8 — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.: 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Andrew J Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna Morton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Wm. O. Seim

(Address): 462 James St

15 Filed: 7 1927 By: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 14, 1927, that I last saw her alive on May 14, 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Loudon Park — DATE OF BURIAL: May 17 1927

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 Edmondson Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22316

CERTIFICATE OF DEATH

90 E 22316

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2819 Woodbrook Ave. St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Whaley,

(a) RESIDENCE NO. 2819 Woodbrook Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 9 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) December 6, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	49	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Polisher No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Whaley,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Carey,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Lewis Godfrey,

(Address) 2819 Woodbrook Ave.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MAY 17 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1927 to May 16 1927,

that I last saw him alive on May 15 1927

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ... yrs. 4 mos. ... da.

CONTRIBUTORY (Secondary) None

(duration) ~ yrs. ~ mos. ~ da.

18 Where was disease contracted

If not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn, M. D.

May 16, 1927 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL New Cathedral

Date of Burial MAY 18 1927

20 UNDERTAKER Geo W Little

ADDRESS 3700 Edmondson Ave

Key important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22317

CERTIFICATE OF DEATH

74-001 E 22317

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 614 Claymont St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Eckert

(a) RESIDENCE NO. 614 Claymont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Peter R Eckert

6 DATE OF BIRTH (month, day, and year): August 4, 1863

7 AGE — Years: 63 — Months: 9 — Days: 11

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Co.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Hagsamm

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Speth

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Peter R Eckert

(Address): 614 Claymont St

15 Filed MAY 17 1927 19 C. HAMPSON JONES, M. D. Registrar

By RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 13, 19 27, to May 15, 19 27, that I last saw h alive on May 15, 19 27, and that death occurred, on the data stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Hennessy, M. D.

19 27 (Address) 280 Edmondson Ave

May 14,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL: Holy Redeemer

Date of Burial: MAY 18 1927 19

20 UNDERTAKER: Geo W Little

ADDRESS: EDMONDSON AVE

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Luigiano Di Franco.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22318

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. E 22318

City of BALTIMORE: (No. 1125 Exeter St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luigiano Di Franco

(a) RESIDENCE NO. 1125 Exeter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Luigiano

6 DATE OF BIRTH (month, day, and year): May 29 '27

7 AGE: Years — Months: 1 — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Mariano Di Franco

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Louisa Allora

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy.

14 Informant: Mariano Di Franco

(Address): 1125 Exeter.

15 Filed: JUN 1 1927 Filed by: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1927

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to May 16, 1927,

that I last saw h[illegible] alive on May 15, 1927,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): General Inertia

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 102 E Fortieth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent's Date of Burial: May 17 1927

20 UNDERTAKER: Frank Coorbaugh ADDRESS: 1906 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22319 ✓001 X60-001 E 22319

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

2-FULL NAME James A Lee Jr.

(a) RESIDENCE NO. Cumberland Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 3rd 1894

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
32	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) W Virginia

PARENTS

10 NAME OF FATHER James A Lee Sr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Oakland Md

12 MAIDEN NAME OF MOTHER Delia Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington D.C.

14 Informant James A Lee Sr

(Address) Cumberland Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Dept. James A Lee Sr. Via B+O.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-17-27

17

I HEREBY CERTIFY, That I attended deceased from 3-27 19 27, to 5-17 19 27, that I last saw h.i.m alive on 5-17 19 27, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) thyrotoxicosis(?) Cardiac Hypertrophy and Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max H Krenfeld, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — Date of Burial 5/19 19 27

20 UNDERTAKER: Martin Fahey Home — ADDRESS 1829 W Northern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 22320

CERTIFICATE OF DEATH.

E 22320

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N. Mount St. St. 15-27 WARD)

2-FULL NAME Emma Jeter

(a) RESIDENCE No. 1327 N. Mount St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morgan Jeter

6 DATE OF BIRTH (month, day, and year) 1-30-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alfred Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lucinda Sindy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Morgan Jeter
(Address) 1327 N. Mount St.

15 Filed ... 19 ... Registrar

E. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-30- 1927, to 5-15- 1927,

that I last saw h alive on 5-15- 1927,

and that death occurred, on the date stated above, at 1 15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Cardio-renal-Vascular dis

(duration) about yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) George C Ray M. D.

19 (Address) 1962 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL May 17 1927

UNDERTAKER Thomas E. Kelson — ADDRESS 1803 Pulaski

Spec.—1-12-23—M&T—500 Blks.

Raymond Elroe Jenkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22321

100-001

CERTIFICATE OF DEATH.

E 22321

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Rayna and Dukeland ST.) 16-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Elroe Jenkins

(a) RESIDENCE NO. 2 932 Elliott Street, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 2 - 1921

7 AGE: Years 6 | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, md

10 NAME OF FATHER: Raymond E Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, md

12 MAIDEN NAME OF MOTHER: Nellie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, md

14 Informant: Raymond Jenkins (Address) 2132 Elliott St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/15 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/9 1927 to 5/15 1927 that I last saw him alive on 5/15 1927 and that death occurred, on the date stated above, at 6 25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller M. D.

19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: May 18 1927

20 UNDERTAKER: William Cook

ADDRESS: 501 E Hoffman

Spec.–7-17-26—A Co.—200 Bks.

E 22322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22322

1-PLACE OF DEATH

REGISTERED NO. 15-65

City of BALTIMORE: (No. 3812 Dalrymple Ave St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Watts

(a) RESIDENCE NO. 3813 Dalrymple Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Watts

6 DATE OF BIRTH (month, day, and year): Sept 19, 1859

7 AGE: Years 67 Months 7 Days 21 27

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hamburg (State or country) N. J.

PARENTS

10 NAME OF FATHER John Watts

11 BIRTHPLACE OF FATHER (City or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant (Address) R. H. Cassel 3812 Dalrymple Ave

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

Via Permit Rpt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 19 27, to May 16, 19 27, that I last saw him alive on May 13, 19 27, and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

about 5

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Cassel, M. D.

N. 16, 19 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hamburg N. J.

Date of Burial: Nov. 18 1927

20 UNDERTAKER: Jos. Cook

ADDRESS: 602 E. Lan...

Key important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22323

CERTIFICATE OF DEATH.

57

E 22323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215 N Montford (St.) 8-12 (Ward)

2-FULL NAME Louise Scherer

(a) RESIDENCE NO. 1215 N Montford ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Henry Scherer

6 DATE OF BIRTH (month, day, and year) Nov 12th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Deutsch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna C. Zeek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant C Howard Scherer
(Address) 806 Talbot Road

15 Filed MAY 17 1927, 19 C. HAMPSON JONES, M. D.
Reg. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1921, to May 15, 1927, that I last saw her alive on May 15, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes + Arteriosclerosis

(duration) 6 yrs. 3 mos. 10 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Data

(Signed) Albert Livingood, M. D.

5/16, 1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 18th 1927

20 UNDERTAKER: George A Billingsley Sons — ADDRESS: 1126 Monument St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 22324

CERTIFICATE OF DEATH.

1527 E 22324

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 W. Hoffman St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hayes Mallory

(a) RESIDENCE NO. 615 W. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Mallory

6 DATE OF BIRTH (month, day, and year) about 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonemason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Ned Mallory

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Lucy Mallory

(Address) 615 W. Hoffman St.

15 Filed ..... 19 .....

By ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.

(Coroner)

May 15, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial May 17 1927

20 UNDERTAKER Samuel Easton ADDRESS 916 Gay St.

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22325

CERTIFICATE OF DEATH.

31 E 22325

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1118 Peach Alley. St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernestine Gilmore.(C)

(a) RESIDENCE NO. 1118 Peach Alley. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ---------

6 DATE OF BIRTH (month, day, and year): June 24, 1905.

7 AGE: Years 21 Months 10 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Washington, D. C.

PARENTS

10 NAME OF FATHER: Elijah Gilmore.(C)

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Washington, D. C.

12 MAIDEN NAME OF MOTHER: Carrie Rhodes.(C)

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore, Md.

14 Informant: Mary Pearsell.(C)

(Address) 1118 Peach Alley.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MAY 17 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)

5/17 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem Date of Burial: May 17 1927

20 UNDERTAKER: Daniel Easton ADDRESS 716 Gay ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22326

CERTIFICATE OF DEATH.

38 ✓ E 22326

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 3233 Powhattan St. Ward) 15-61

2-FULL NAME Madeline Elizabeth Scott

(a) RESIDENCE NO. 3233 Powhattan St. Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of George Scott

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rockville

(State or country) Md.

PARENTS

10 NAME OF FATHER James Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Rockville Md.

12 MAIDEN NAME OF MOTHER Lizzie Powell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant George Scott

(Address) 3233 Powhattan Ave.

15 Filed 6 1927 16 C. HAMPSON JONES, M. D., Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 14, 1927, that I last saw h.er alive on May 13, 1927, and that death occurred, on the date stated above, at 6-30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Initial)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY Bronchial asthma

(Secondary)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Wallace Jones, M. D.

, 19 (Address) 1701 Pa Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville, Md. Date of Burial May 17 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22327

CERTIFICATE OF DEATH.

E 22327
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Madison Ave ~~St.~~ 7-9 WARD)

2-FULL NAME William E Cook

(a) RESIDENCE NO. 1512 Mc Elderry ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rebecca Cook

6 DATE OF BIRTH (month, day, and year) Mch 7 day? 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer unknown

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James E Cook

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Melvin Campion
(Address) 1705 N Bond St

15 Filed 5/17 1927 . 19 .... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 . 1927 . to May 14 . 1927 . that I last saw h alive on May 14 . 1927 . and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R J Cotton M. D.

5/18 . 19 27 (Address) 1424 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL May 18 1927

20 UNDERTAKER Saml T Kennedy

ADDRESS 578 N Bradde

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22328

CERTIFICATE OF DEATH.

31

E 22328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3419 Madison Avenue ST. 13-54 (WARD)

2-FULL NAME George E. Bryson

(a) RESIDENCE NO. 3419 Madison Avenue ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Bryson

Dec 4 1895

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor 044

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town) Hurricetown Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Bryson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Irene Hampton

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ruth Bryson
(Address) 2419 Madison Ave

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 14, 1927.

that I last saw him alive on May 14, 1927

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

ACUTE NEPHRITIS

(duration) Dont know yrs. mos. ds.

CONTRIBUTORY (Secondary) TUBERCULOSIS

(duration) Dont know yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H White M. D.

, 19 (Address) 1039 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL May 17 1927

20 UNDERTAKER Samuel J Handley — ADDRESS 578 W Biddle

ATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22329

CERTIFICATE OF DEATH.

129 E 22329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3721 Hillsdale (STREET) (WARD) REGISTERED NO. 9764

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Thomas Ports

(a) RESIDENCE No. 3721 Hillsdale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Ports

6 DATE OF BIRTH (month, day, and year) June 8 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Lutz

(Address) 3721 Hillsdale

15 Filed May 16 1927 C. HAMPSON JONES, M. D. Registrar

Ref. RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1927 to May 14 1927, that I last saw him alive on May 14 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uraemic Convulsions

Chronic Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Wesley, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL May 16 27

20 UNDERTAKER W. J. Faulmann Sons ADDRESS Balto Md

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 22330

CERTIFICATE OF DEATH.

E 22330

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: Pronounced dead at St. Joseph Hospital St. 10-14 Ward)

City of BALTIMORE: (No.

2-FULL NAME: John Hutchins

(a) RESIDENCE NO. 803 Somerset St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Luia Hutchins

6 DATE OF BIRTH (month, day, and year): Aug 10/1891

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
35	35	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: self

9 BIRTHPLACE (city or town):

(State or country): Balto., Md

PARENTS

10 NAME OF FATHER: John Hutchins

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto. Co., Md

12 MAIDEN NAME OF MOTHER: Malinda Hutchins

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Ci., Md

14 Informant: Julia Hutchins

(Address): 803 Somerset St.

15 Filed: 19 Per: Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16/19 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia -Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Mason, M. D.

(Coroner)

5/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: 5/19/27

20 UNDERTAKER: Mrs. P. A. Elliott — ADDRESS: 1223 Ashland Ave.

NOV 17 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22331

CERTIFICATE OF DEATH.

129 E 22331

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Keyser St S. 8-16 WARD)

2-FULL NAME Francis Jones

(a) RESIDENCE No. 2115 Keyser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Jones.

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. Jones (Address) 2115 Keyser st.

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9 - 1927 to May 14 1927.

that I last saw her alive on May 14 1927.

and that death occurred, on the date stated above, at 10.30 Am.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Nephritis (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis Complication Disease (duration) yrs. 7 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Postive

(Signed) Dr J W Kennard, M. D.

5-14 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL 5/17/27

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1720 Ashland av

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

CERTIFICATE OF DEATH.

E 22332

REGISTERED NO. E 22332

1-PLACE OF DEATH

City of BALTIMORE: (No. 1936 Bank St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Kochanowski

(a) RESIDENCE NO. 1936 Bank St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9 - 27

7 AGE: Years | Months | Days: 7 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Adam Kochanowski

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: K Krumm

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Adam Kochanowski

(Address) 1936 Bank St

Filed MAY 7 1927 H. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/16 19 27

17 I HEREBY CERTIFY, That I attended deceased from 5/14, 1927, to 5/16, 1927, that I last saw h.z. alive on 5/14, 1927, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Urology Pertinacum

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edward Strube M. D.

5/16 19 27 (Address) 1328 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial May 7 1927

20 UNDERTAKER: J. W. Ozazewski ADDRESS 1930 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

E 22333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1927 E 22333

1-PLACE OF DEATH South Balto Gen. Hosp. Light. REGISTERED NO. 24-33

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude Marion Wagner.

(a) RESIDENCE NO. 701 E. 7th St. Sparrows Pt. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Owen F. Wagner.

6 DATE OF BIRTH (month, day, and year): March 1 - 1898

7 AGE: Years: 29 years. Months: 2 mos. Days: 14. IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Richmond, Va.

PARENTS

10 NAME OF FATHER: Edward Oakley

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Richmond, Va.

12 MAIDEN NAME OF MOTHER: Ellen G. Gifford.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Richmond, Va.

14 Informant: Owen F. Wagner. (husband)
(Address) 701 E. 7th St. Sparrows Point.

15 Filed ____, 19____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-15-27. 19

17 I HEREBY CERTIFY, That I attended deceased from 5-11, 1927, to 5-15, 1927, that I last saw h[illegible] alive on 5-15, 1927, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:
General peritonitis

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary): Abortion. self-induced

(duration) ____ yrs. ____ mos. 6 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Yes Date of 5-12-27
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) E. Klassen, M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial: May 16 1927

20 UNDERTAKER: Robt J Turner Sons ADDRESS: 1443 E Broadway

Filed May 17 1927 RAC

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 22334

CERTIFICATE OF DEATH.

E 22334

10-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 26-11 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Potter

(a) RESIDENCE NO. 3414 E. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Oct 28, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ...min.
4	5	6	18	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Chas E. Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary A. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Chas. E. Potter

(Address) 3414 E Fairmount Ave

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 10, 1927, that I last saw him alive on May 10, 1927, and that death occurred, on the date stated above, at 7 15 a m

The CAUSE OF DEATH* was as follows:

Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Cult.

(Signed) Myron G. Tull, M. D.

5/17 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/18 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mulberry

Cor.—12-9-25—A Co.—200 Bks.

Trezzin

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22335

CERTIFICATE OF DEATH.

E 22335

1-PLACE OF DEATH

City of BALTIMORE: (No.) Franklin Sq. Hospital (St.) (Ward)

REGISTERED NO. 19185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME George Trezzin

(a) RESIDENCE NO. 2107 Boyd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27th 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER John Trezzin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Roumania

12 MAIDEN NAME OF MOTHER Mary Fischer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

14 Informant Mary Trezzin

(Address) 2107 Boyd St

15 Filed MAY 7 1927

Ref. R.I.

G. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
Internal Hemorrhage 3 Hrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jumped off Trestle in front of truck
(duration) yrs. mos. ds.

May 16 1927 (Signed) Thos. B. Horton M. D.
(Coroner)
(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See rules and directions on back.) Balto Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial May 19 1927

20 UNDERTAKER Engelke Funeral Home ADDRESS Fulton & Fayette

Cor.—12-9-25—A Co.—200 Bks.

E 22336

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22336

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 17-24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elaine Malloy

(a) RESIDENCE NO. 1226 Druid Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Malloy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Nordenholt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant James Malloy

(Address) 1226 Lemmon Hill Ave

15 Filed [illegible] 1927 16 C. HAMPSON JONES, M. D. Registrar

Per [signature]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

(Coroner)

5/16/1927 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Asbury Cemetery 5-17 1927

20 UNDERTAKER George T. U. Gibson ADDRESS 1736 Linden Avenue

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22337

CERTIFICATE OF DEATH.

H 9 E 22337

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospt. ST. 11-24 WARD)

2-FULL NAME Thomas Lloyd Shields

(a) RESIDENCE NO. 1207 Linden Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced,~~ (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 20. 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edward Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary E. Shields

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary E. Shields

(Address): 1207 Linden ave

15 Filed 19 C. HAMPSON JONES, M.D. Registrar

11 7 1927. R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1926, to May 16, 1927,

that I last saw him alive on May 16, 1927,

and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx.

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure - Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? None.

What test confirmed diagnosis? Bronchoscopic.

(Signed) James W. Nelson, M. D.

, 19 (Address) Mercy Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: Green Mount

DATE OF BURIAL: May 19 1927

20 UNDERTAKER: Chas O. Mitchell Sons

ADDRESS: 1900 Eutaw Place

Spec.—12-9-25—A Co.—200 Bks.

Certificate Corrected 2-3-49.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 2498

E 22338

CERTIFICATE OF DEATH.

+86-00-2

E 22338

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No.) St., 7-9 Ward)

2-FULL NAME Maggie Mrs Morris

(a) RESIDENCE NO. Marion - N. C. - St. Ward

(Usual place of abode) Marion

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm L. Morris

6 DATE OF BIRTH (month, day, and year): May 14, 1892

7 AGE: Years 35; Months; Days 2; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Ga.

(State or country)

PARENTS

10 NAME OF FATHER: Edgar L. Rogers

11 BIRTHPLACE OF FATHER (city or town): Ga.

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Chambers

13 BIRTHPLACE OF MOTHER (city or town): Ga.

(State or country)

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

MAY 17 1927

Filed

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to May 16, 1927, that I last saw h[illegible] alive on May 16, 1927, and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis Pneumococcus.

Mastoiditis left.

Origin of meningitis probably from Mastoid

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? yes. Date of April 26 27 May 5 27

Was there an autopsy? yes.

What test confirmed diagnosis? Operation + Autopsy

(Signed) [signature], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marion, N. Carolina

Date of Burial: May 19 27

20 UNDERTAKER: John O. Wilderman Sons

ADDRESS: 1900 Eutaw

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22339

CERTIFICATE OF DEATH.

E 22339

REGISTERED NO. 25463

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. (22nd WARD)

2-FULL NAME Dr. Alfred E Curtis

(a) RESIDENCE NO. Mt Hope Retreat ST., 27 WARD Petersburg Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. 3 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Petersburg Va

PARENTS

10 NAME OF FATHER P. H Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg Va

12 MAIDEN NAME OF MOTHER Mary M. Braman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg Va

14 Informant E. Marie Curtis (wife)
(Address) Washington D.C.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to May 16, 1927, that I last saw he alive on May 16, 1927, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Epileptic Convulsion (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dementia Praecox (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mental Examination & Observation

(Signed) C. B. Lawson M. D.

5-17-1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va.

DATE OF BURIAL May 17 1927

20 UNDERTAKER D. STEWART & HOWEN COMPANY (WILLIAM F. WOODER, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—12-9-25—A Co.—200 Bks.

See Letter on file from C. Holmes Boyd MD 120 (May 19-1927)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22340

CERTIFICATE OF DEATH.

REGISTERED NO. E 22340

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 21-29 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John (Owens) Lee Dundon

(a) RESIDENCE NO. 601 Archer St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town):

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) ?

14 Informant:

(Address) Records

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 15, 1927, that I last saw h~~im~~ alive on May 14, 1927, and that death occurred, on the date stated above, at 8:25 A m.

The CAUSE OF DEATH* was as follows:

acute Yellow Atrophy Liver

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith M. D.

May 19 27 (Address) [redacted] MORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Agustan Cemetery Date of Burial May 17 27

20 UNDERTAKER: Thos. Fields ADDRESS 200 W Lombard

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22341

CERTIFICATE OF DEATH.

74001

E 22341

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 W. Biddle St. 17th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Gibbs

(a) RESIDENCE NO. 517 W. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) about 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. L. R. Robinson

(Address) 517 W. Biddle St.

15 Filed May 14, 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. HAMPSON JONES, M. D. (Coroner)

May 14, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 5/17 1927

20 UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave.

V 7 1927

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22342

CERTIFICATE OF DEATH

E 22342

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 35 Mallow Hill ave St. 28-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Tatum

(a) RESIDENCE NO. 35 Mallow Hill ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Daniel Tatum

6 DATE OF BIRTH (month, day, and year) april 12 = 1846

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	81	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) md

PARENTS

10 NAME OF FATHER Henry Spetzler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant James E. Tatum

(Address) 2032 Hollins st

15 Filed MAY 17 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1917 to May 15, 1927, that I last saw h[illegible] alive on May 15, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell M. D.

May 16, 1927 (Address) 1644 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 5-18-1927

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun Hollins

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

see letter in file

HEALTH DEPARTMENT—CITY OF BALTIMORE

22343

CERTIFICATE OF DEATH.

31 E 22343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 25 Berwick Ave (St.) (Ward) 27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Zetzer

(a) RESIDENCE NO. 25 Berwick Ave ST., Hamilton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Katie Zetzer

6 DATE OF BIRTH (month, day, and year) Nov 15, 1862 Est

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
65 75	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 0/3

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Jacob Zetzer (Address) 42 Berwick Ave.

15 Filed 7-1927, 19 C. HAMPSON JONES, M. D. Registrar RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from November, 1926, to May 17, 1927, that I last saw h~~is~~ alive on May 11, 1927, and that death occurred, on the date stated above, at 12.00 Am.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis several (duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) Asthma & pulm. tuberculosis several (duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. M. Bacon, M. D.

5/17, 1927 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dehren Borchel

DATE OF BURIAL 5/18 1927

20 UNDERTAKER Jagle Lewis ADDRESS 1439 Eutaw St

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22344

CERTIFICATE OF DEATH.

9z E 22344

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abe Davison

(a) RESIDENCE NO. 3008 Clifton St. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Davison

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 50 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Max Burlovitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Ida —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Rose Davison

(Address): 3008 Clifton Ave

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: May 17

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 17, 1927, that I last saw h[illegible] alive on May 11, 1927, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Popliteal Artery

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism Auricular Fibrillation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of May 2nd 27 Amputation of Leg

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Abram L. Blechman, M. D.

5-17, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. Date of Burial 5/18 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E. Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 22345

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22345

CERTIFICATE OF DEATH.

12-50 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2846 N. Calvert ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Bowyer Browne

(a) RESIDENCE NO. 2846 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Lee McComas

6 DATE OF BIRTH (month, day, and year) June 4, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	64 65	11	12 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auditor

(b) General nature of industry, business, or establishment in which employed (or employer) 0/3

(c) Name of employer B. & O. Railroad

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter A. Browne

11 BIRTHPLACE OF FATHER (city or town) Phila.

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Helen Scott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to May 16, 1927.

that I last saw h[illegible] alive on May 16, 1927

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. W. Keen, M. D.

5-17, 1927 (Address) St Paul & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Horace A. Browne

(Address) 1006 Park Avenue

15 Filed 7 1927 By C. HAMPSON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 5/18 19 27

20 UNDERTAKER Henry H. Dears & Son

ADDRESS 805 N. Calvert St.

Spec.—1-12-23—M&T—500 Bks.

(Schriefer)

E 22346

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22346

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 8 ..... WARD)

2-FULL NAME John L Schriefer

(a) RESIDENCE No. 1504 N. Broadway St.; ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Schriefer

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooker

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer City

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER George Schriefer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Engelhardt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Carrie Schriefer (Address) 1504 N Broadway St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to May 16, 1927, that I last saw h— alive on May 16 1927 and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E Mills, M. D.

19 ..... (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 19 1927
20 UNDERTAKER	ADDRESS
Bernard A Finke	734 Poplar Grove St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22347 E 22347

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude F Cole.

(a) RESIDENCE NO. 2 Talbot Ave Balto Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lewis S. Leale

6 DATE OF BIRTH (month, day, and year): Nov 2 1887

7 AGE: Years 39 Months 6 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Trained Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Stuttgart Germany

PARENTS

10 NAME OF FATHER: Albert A. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Albertina Clearwater

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma L. Lehner

(Address) Elizabeth Ave Lansdowne Md.

15 Filed 7 1927

C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1927.

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1927. to May 16, 1927.

that I last saw h[illegible] alive on May 16, 1927.

and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(cause)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Cultures

(Signed) E R Miller M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cemetery Towson Md

DATE OF BURIAL: May 18 1927

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22348

CERTIFICATE OF DEATH.

E 22348

REGISTERED NO.

1-PLACE OF DEATH Broadway Eastern av 16-67

City of BALTIMORE: (No. Merchants National Bank Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Flitton

(a) RESIDENCE NO. 904 Caton ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Flitton

6 DATE OF BIRTH (month, day, and year) July 4th 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	10	12 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Bank

(c) Name of employer Merchants National

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Noah Flitton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Herbert H Flitton

(Address) 4012 Eldorado ave

15 Filed May 19 1927 C. LAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) Sudden yrs. mos. ds.

(Signed) James H Fenton M. D.

(Coroner)

5-17-1927 (Address) 700 Chanel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: May 19 1927

20 UNDERTAKER: Chas. S. Black — ADDRESS: 742 W. North ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22349 E 22349

CERTIFICATE OF DEATH.

11-15 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 N Charles ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Merrill

(a) RESIDENCE NO. 929 N Chas St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C Merrill

6 DATE OF BIRTH (month, day, and year) 2-22-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	2	23 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos B Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhemia Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W M Halliday (Address) Annapolis

15 MAY 1927 C. HAMPSON JONES, M. D. Registrar

Per R.P.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1927

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to May 17th, 1927,

that I last saw her alive on May 10th, 1927,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Coronal Sclerosis.

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) J A Halliday, M. D.

May 17, 1927 (Address) 1300 Druid St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass

DATE OF BURIAL May 16, 1927

20 UNDERTAKER E Le Roy Stiffler

ADDRESS 125 E North Ave

E 22350

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

7H-001

E 22350

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1737 Mabelle St. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosina Watkins

(Residence in Baltimore: No. 1737 Mabelle St.; 3 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: April ? (Month) (Day), 1880 (Year)

7-AGE: 47 yrs. ? mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): O'D

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Cornelius Woodland

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Maggie Forest

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James E. Woodland

(Address) La Plata Md.

15- C. HAMPSON JONES, M. D.

Filed ..... 1927 ..... 191 ..... Per ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 16th (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to May 16 1927, that I saw her alive on May 16 1927, and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) About 30 mos. ..... ds.

Contributory (SECONDARY) Congestive terminal

Pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. P. Dayerly M. D.

May 17th 1927 [Address] 502 S. W. North

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: La Plata Md DATE OF BURIAL: 5/18/ 1927

20-UNDERTAKER: Mrs. Geo. H. Holland ADDRESS: 1631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

E 22351 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO.) ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eva Reed

(a) RESIDENCE NO. 1700 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Frederick Co Md

PARENTS

10 NAME OF FATHER: Dr Rob. M. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Henrietta Wenzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs E. A. Reed

(Address) 1700 Eutaw Pl

15 Filed 7 1927 C. HAMPSON JONES, M. D., Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to May 16, 1927, that I last saw h[er] alive on May 16, 1927, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis a
Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 20-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Hg, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

DATE OF BURIAL: May 20 1927

20 UNDERTAKER: Harry W. Ellen

ADDRESS 1944 N. North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22352

CERTIFICATE OF DEATH.

40 E 22352

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. H-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME May Amendt

(a) RESIDENCE NO. 408 S. Highland Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22/1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) ....

(State or country) Phila., Pa.

PARENTS

10 NAME OF FATHER Charles Scott

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Hempel

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Ireland

14 Informant John Scott (Bro)

(Address) 3157 Edgewood Place.

15 Filed 7 1927 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis- Chr Salpingitis- Paralytic Ileus.
(Autopsy at Hopkins)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Sellers M. D.
(Coroner)

5/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Phila Pa. Date of Burial May 18 1927

20 UNDERTAKER George W Zirkler ADDRESS 1731 E Eager St

Spec.-7-17-26—A Co.—200 Bks.

E 22353

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22353

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. E. B. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Bevans

(a) RESIDENCE NO. 2019 McCulloh st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Bevan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 18, 27 to May 16, 27

that I last saw her alive on May 16, 27

and that death occurred, on the data stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gallaher M. D.

5-16-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem May 18 27

20 UNDERTAKER — ADDRESS

Daniel Easton 916 Cam

Very important.—See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22354 — CERTIFICATE OF DEATH — E 22354

100-021

REGISTERED NO. 17-24

1-PLACE OF DEATH

City of BALTIMORE: (No. 534 Oxford St. Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Ann Booker

(a) RESIDENCE NO. 534 Oxford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10/11 25

7 AGE: Years 1 Months 7 Days 5

IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Booker

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Emilie Timmons

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Emeline Booker

(Address) 534 Oxford St.

15 Filed MAY 17 1927 C. HAMPSON JONES, M. D. Registrar

Plot RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/ 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 16, 1927

that I last saw h.. alive on May 16, 1927

and that death occurred, on the date stated above, at 10:50 P. M.

The CAUSE OF DEATH* was as follows:

Auto Injuries

(duration) yrs. 1 mos. da.

CONTRIBUTORY Bronchio-pneumonia

(Secondary)

(duration) yrs. mos. 3 da.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tomkins, M. D.

(Address) 1019 Dill Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial May 17 1927

20 UNDERTAKER: Dennis Eaton — ADDRESS 516 Race

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22355

CERTIFICATE OF DEATH

129 E 22355

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 717 Linnard St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Eldridge Chaney,

(a) RESIDENCE NO. 717 Linnard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Prudence A. Chaney,

6 DATE OF BIRTH (month, day, and year) November 17, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	69	6	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. R. Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer) R. R. 073

(c) Name of employer B & O. R. R

9 BIRTHPLACE (city or town) Frederick Co. Md

(State or country)

PARENTS

10 NAME OF FATHER George Chaney,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Armella Mathais

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. P. A. Chaney,

(Address) 717 Linnard St.

15 Filed 19 C. HAMPSON JONES, M. D.

MAY 1927 Per pkb Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1924, to May 17, 1927, that I last saw him alive on May 16, 1927, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthro sclerosis Int Nephritis and valvular Heart disease

(duration) over 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry E. Onkes M. D.

May 17 19 27 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

Date of Burial MAY 20 1927

20 UNDERTAKER Geo W Little

ADDRESS

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 22356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22356

CERTIFICATE OF DEATH.

27-538

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3902 Hadley Square East (WARD) 27

2-FULL NAME Robert Price,

(a) RESIDENCE NO. 3902 Hadley Square East St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Price

6 DATE OF BIRTH (month, day, and year) April 3, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	71	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waterbury, Conn.

PARENTS

10 NAME OF FATHER Carl Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. J. G. Stiefel
(Address) 3902 Hadley Square East.

15 Filed 7-1927 C. HAMPSON JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1926 to May 16, 1927, that I last saw him alive on May 16, 1927, and that death occurred, on the date stated above, at 7.10 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. V. Tavolacci, M. D.

5/17, 1927 (Address) 24 N. Fulton Ave..

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL MAY 20 1927

20 UNDERTAKER Geo. W. Little
Geo. W. Little

ADDRESS 3708 Edmondson Ave

Spec.–7-17-26—A Co.—200 Bks.

E 22357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22357

CERTIFICATE OF DEATH

7/4-001

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2003 Etting St. (Ward) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George I. Palmer

(a) RESIDENCE NO. 2003 Etting St. Ward

(Usual place of abode) 30

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline Palmer

6 DATE OF BIRTH (month, day, and year): Dec 11, 1877

7 AGE: 49 Years 5 Months 3 Days — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Thos. Palmer

11 BIRTHPLACE OF FATHER (City or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Laura Young

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant: Pauline Palmer

(Address) 2003 Etting St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9 1927 to May 15 1927

that I last saw h[illegible] alive on May 15 1927

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Fletcher M. D.

5/17 1927 (Address) 1225 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: May 18 1927

20 UNDERTAKER: Thomas E. Kelsey. — ADDRESS: 307 Pressman.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 22358

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22358

CERTIFICATE OF DEATH.

15-56 21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 198 St. Ambrose Avenue ST. 15-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Helene Molloy

(a) RESIDENCE NO. 198 St. Ambrose Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE --------

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis X. Molloy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katharine H. Doyle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Francis X. Molloy
(Address) 198 St. Ambrose Avenue

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927

E°83.

I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to May 16, 1927, that I last saw h[er] alive on May 16- 1927, and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pennington, M. D.

5.17. 1927 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/18 1927

20 UNDERTAKER Henry W. Myers & Son

ADDRESS 805 N. Calvert

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22359

CERTIFICATE OF DEATH.

185

E 22359

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. St., 18-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Henry

(a) RESIDENCE NO. 322 (322) N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Sept 12-1848

7 AGE: Years: about 78 ~~XX~~ Months: 8 Days: 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Red Lion, Del

(State or country)

PARENTS

10 NAME OF FATHER: James Henry

11 BIRTHPLACE OF FATHER (city or town): U S A

(State or country)

12 MAIDEN NAME OF MOTHER: Matilda Morrison

13 BIRTHPLACE OF MOTHER (city or town): U S A

(State or country)

14 Informant: Dr. Henry

(Address) 2589 Bedford Ave Brooklyn N Y

15 Filed....., 19..... RHH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held a Inquest on the body and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by me, including the (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH was as follows: Fract Skull

(duration) ..yrs. 28 hrs

CONTRIBUTORY (Secondary) Fell down Steps (man was blind)

(duration) ..yrs. ..mos. ..ds.

(Signed) Thos B. Horton M. D.

(Coroner)

May 17 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See rules on reverse side.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

(If not at place of death) Where was disease contracted?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn N Y — Date of Burial: May 19 27

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22360

CERTIFICATE OF DEATH.

90

E 22360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2058 Linden Ave St.) (Ward 20)

2-FULL NAME Elizabeth H. Dberer

(a) RESIDENCE NO. 2058 Linden Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 29 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Dberer

6 DATE OF BIRTH (month, day, and year) Dec. 18 1846

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Ross Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs. Alice P. Todd

(Address) 2058 Residence.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Thomas M. D.

(Coroner)

5/17, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial May 19 27

20 UNDERTAKER Wm. J. Fleckner Sons ADDRESS Norfolk Va

Key Industries. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22361

E 22361

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St., 76-37 Ward)

2-FULL NAME James Bell

(a) RESIDENCE NO. Fairfield Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Bell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smallwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) [redacted]

Filed MAY 18 1927

Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1927

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to May 14, 1927, that I last saw him alive on May 14, 1927, and that death occurred, on the date stated above, at 9:55 m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and
Pneumonia
Hydrothorax rt.

(duration) yrs. mos. ds.

CONTRIBUTORY Myocardial failure
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & laboratory

(Signed) R. Hooper Lamb, M. D.

May 16 1927 Address BALTIMORE CITY HOSPITALS

State the Disease [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch Ct. Date of Burial May 18 1927

20 UNDERTAKER Ulysses Brown & Son ADDRESS 1038 W Mondawmin

Spec.—1-10-21—M&T—1500 Bks.

E 22362

E 22362

HEALTH DEPARTMENT—CITY OF BALTIMORE

STATE BIRTH NO. 17202

CERTIFICATE OF DEATH.

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1056 Penna Ave ST., 17-24 WARD)

2-FULL NAME Baby Boy Evans II 2

(a) RESIDENCE NO. 1052 Penna ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colore

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-11-27

7 AGE — Years | Months | Days | If LESS than 1 day, 3 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lawrence J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Julia Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) C. HAMPSON JONES, M. D.

15 Filed MAY 18 1927 By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-11, 1927. to 5-11, 1927.

that I last saw h[illegible] alive on 5-11, 1927.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Maternal Syphilis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature & Congenital debility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Ed Dodger, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

E 22363

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1056 Penna ST. 17-24 WARD) 38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Evans #1

(a) RESIDENCE No. 1056 Penna ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-11-27

7 AGE: Years | Months | Days: 1 | If LESS than 1 day 2 hrs. or 35 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ~~Mabel Martha~~ Dorothy Julia Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed MAY 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-11 .1927 to 5-12 .1927.

that I last saw him alive on 5-12 .1927.

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

Maternal Syphilis (Premature)

(duration) hrs mos ds.

CONTRIBUTORY (Secondary) ~~atelectasis~~ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eva F. Dodge M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22364

CERTIFICATE OF DEATH

129

E 22364

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 Hilliams St. 24-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conway, Margaret

(a) RESIDENCE NO. 1740 Johnson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5 1890.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	37	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ore Iron Co

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Frederick Conway

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Brinkman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catherine Conway

(Address) 1740 Johnson

15 Filed ... C. HAMPSON LEWIS, M. D. Registrar

MAY 18 1927 Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

May 15

17 I HEREBY CERTIFY, That I attended deceased from

May 10, 1927, to May 15, 1927

that I last saw ~~he~~ alive on May 15, 1927

and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos. 5 da.

CONTRIBUTORY Uremia
(Secondary)

(duration) yrs. mos. 2 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. K. Campbell M. D.

May 16, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cedar Hill	May 18 1927

20 UNDERTAKER William Cole Sons & Co. ADDRESS

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22365

CERTIFICATE OF DEATH.

22-31 29

E 22365

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 822 Hanover St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda J. Frank.

(a) RESIDENCE NO. 822 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If ~~married, widowed, divorced~~ (or) WIFE of John Frank.

6 DATE OF BIRTH (month, day, and year) February 22 1845

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	82	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ;----- Morgan.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Bertha R. Rost. (daughter.)

(Address) 822 Hanover St.

15 Filed ..... 19 ..... C. HAMPSON JONES M. D. Registrar

5/18 1927 Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

5/17, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 822 Hanover Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial May 18 1927

20 UNDERTAKER Milton Cook ADDRESS 520 E. Lafayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22366

CERTIFICATE OF DEATH.

201 E 22366

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 4-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sydney Norris

(a) RESIDENCE NO. 144 Market St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Norris

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
51 50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER A. Norris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Stevens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Edna V. Schaeffer

(Address) 8 East Lee Street

15 Filed ..... 19 .....

For ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer stomach

Cause unknown probably accidental (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Sunday

(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Peter M. D.

(Coroner)

May 17 1927 (Address) 1629 Eu

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Date of Burial May 18 1927

20 UNDERTAKER W. Cook ADDRESS 600 E Preston

Very important. See instructions on back of certificate.

HAMPSON SONS, M. E.

MAY 18 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22367

CERTIFICATE OF DEATH

101-00

E 22367

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 Sterling St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McEntyre

(a) RESIDENCE NO. 701 Sterling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie McEntyre

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 33 Months Days IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Hoke County N.C.

PARENTS

10 NAME OF FATHER: Archie McEntyre

11 BIRTHPLACE OF FATHER (City or town)

(State or country): N.C.

12 MAIDEN NAME OF MOTHER: Hannah Campbell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): N.C.

14 Informant: Samuel McEntyre

(Address): 701 Sterling St

15 Filed MAY 18 1927 HAMPSON JONES, M. D. Registrar

By R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 15

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 15, 1927, that I last saw him alive on May 15, 1927, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

1. Pleuro Pneumonia Bilateral.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

May 19 27 Address 508 Somerset St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen N. C.

Date of Burial: 5/18 1927

20 UNDERTAKER: Byron Wright

ADDRESS 1218 McElderry St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 22368

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2231 Penna ave St. 13-24 Ward)

2-FULL NAME Albert Louis Perara

(a) RESIDENCE NO. 2231 Penn ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

10 NAME OF FATHER Samuel Perara

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Julia Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

PARENTS

14 Informant Julia Perara

(Address) 2231 Penna ave

15 Filed May 18 1927 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pelio – Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY no other history

(Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 19, 1927 (Address) 702 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk. Date of Burial May 18 1927

20 UNDERTAKER Richard F. Curley ADDRESS 2016 E. Hall ave

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 22369 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 100-001

E 22369

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 N. Fremont Ave ST. 14-20 WARD)

2-FULL NAME Octavius Griffin

(a) RESIDENCE NO. 1335 N. Fremont Ave ST. ____ WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Hannah Griffin

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co. (State or country) Va

PARENTS

10 NAME OF FATHER Ned Griffin

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Sarah Kelley

(Address) 1356 N. Fremont Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

8 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1926 to May 17 1927, that I last saw him alive on Nov 16th, 1926, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) ... yrs. ... mos 9 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

5/17, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem Baltimore Co Md

DATE OF BURIAL May 18 1927

20 UNDERTAKER Cobb & Alexander

ADDRESS [illegible]

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22370

CERTIFICATE OF DEATH.

18-76 31

E 22370

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 807 Vine St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Benn Patterson

(a) RESIDENCE NO. 807 Vine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	11	(?)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 240

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Plant

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Annie Hooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co. Md.

14 Informant John Patterson Jr.

(Address) 807 Vine St.

15 Filed C. HAMPTON JONES, M. D.

MAY 18 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 17th 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 17, 1927, that I last saw h[illegible] alive on May 17, 1927 and that death occurred, on the date stated above, at 12.15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) J. P. Cannell, M. D.

5/18, 1927 (Address) 805 Vine St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Island Creek Calvert Co. Md. Date of Burial 5/20 1927

20 UNDERTAKER: John H. Loadin ADDRESS: 1027 D. Ave.

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22371

CERTIFICATE OF DEATH.

E 22371

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 Mosher (St.) 16-22 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Stewart

(a) RESIDENCE NO. 1406 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 3, 1913

7 AGE — Years: 13 (14) Months: 1 Days: 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co. Md

12 MAIDEN NAME OF MOTHER: Alberta Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co. Md

14 Informant: Alberta Stewart

(Address): 1406 Mosher St

15 Filed: MAY 18 1927 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927, to May 17, 1927, that I last saw h alive on May 16, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Influenza), ?

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm A Wright, M. D.

(Address) 1229 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: May 19 1927

20 UNDERTAKER: Saml. R. Chase & Son — ADDRESS: 1405 Mosher

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22372

CERTIFICATE OF DEATH.

44 E 22372

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Highland ave ST. 16-39 WARD)

2-FULL NAME George Bayer

(a) RESIDENCE NO. 106 N. Highland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Bayer

6 DATE OF BIRTH (month, day, and year) July 8-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John B. Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Katherine Bayer

(Address) 106 N. Highland ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

18 1927 Per K.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to May 16—, 1927 that I last saw him alive on May 15—, 1927 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. D Kerrigan, M. D

May 17 1927 (Address) 7413 E Belton

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 19 1927

20 UNDERTAKER George N. Zinkler — ADDRESS 1739 E. Eager St.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22373

CERTIFICATE OF DEATH

47

E 22373

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 South Calhoun St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles William Kuhn

(a) RESIDENCE NO. 10 South Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 14, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rawlings Implement Co.

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob F. Kuhn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Julia C. Kuhn

(Address) 10 South Calhoun Street

MAY 18 1928 Filed HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1927, to May 16, 1927, that I last saw him alive on May 16, 1927, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Carcinoma Liver

(Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Adelbert Cumming, M. D.

5/17, 1927 (Address) 2000 Hollins Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

Date of Burial May 19 1927

Joseph W. Cook

UNDERTAKER

ADDRESS 1003 N. Eutaw St.

Very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22374

CERTIFICATE OF DEATH

60-001

E 22374

1-PLACE OF DEATH

REGISTERED NO. 20-27

City of BALTIMORE: (No. 310 North Monroe St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Knotts

(a) RESIDENCE NO. 310 North Monore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George S. Knotts

6 DATE OF BIRTH (month, day, and year): May 19, 1856

7 AGE — Years: 70 Months: 11 Days: 27 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Brunswick

(State or country): New Jersey

PARENTS

10 NAME OF FATHER: Jacob Larrimore

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Elizabeth Marsh

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Clarence M. Cook

(Address): 310 N. Monroe St.

15 Filed MAY 18 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to May 16, 1927, that I last saw her alive on May 15, 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Ky. & Hypertension

(duration) 10 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm. E. Cutler M. D.

5/16 1927 (Address) 1319 Light Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

Date of Burial: May 18 1927

UNDERTAKER Joseph W. Cook

ADDRESS 1003 W. Lafayette Ave

Very Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22375

CERTIFICATE OF DEATH.

44

REGISTERED NO. E 22375

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 7-10 WARD)

2-FULL NAME Anna Roppelt

(a) RESIDENCE NO. 620 N Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of David Roppelt

6 DATE OF BIRTH (month, day, and year) Aug 1868

7 AGE: Years 58 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Sarah E. Whittaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Andrew J. Bennett

(Address) 1709 Bond St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to May 15, 1927, that I last saw her alive on May 13, 1927, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 36 hrs

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? Yes Date of 5/13/27

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. F. Busby, M. D.

(Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 18 1927

20 UNDERTAKER: Mrs E. Mullen & Son — ADDRESS: 2334 Jefferson St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 22376

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 Jenkins St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Johnson

(a) Residence No. 1023 Jenkins St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. Johnson

6-DATE OF BIRTH (month, day and year) Feby 14, 1864

7-AGE. 73 yrs. 3 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md (State or Country),

PARENTS.

10-NAME OF FATHER, Geo. Luke

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Anna Ross

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Elizabeth Keller

(Address) 243 Ex. Conway Alley

15- Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16/27

17- I HEREBY CERTIFY, That I attended deceased from Mar 17 1927 to May 16 1927 that I last saw h[illegible] alive on May 14 1927 and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) — yrs. 4 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettelsinn M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Zion Cem

DATE OF BURIAL. May 18 1927

20-UNDERTAKER. Samuel F. Hensley

ADDRESS 578 N Bradford

18 1927 C. HAMPTON JONES

Reg.

Spec.—12-9-25—A Co.—200 Bks.

90 E 6 22377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 38 E 22377

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Thomas

(a) RESIDENCE NO. 116 Pat St. Easton St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colred	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-1-67

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
59 60		9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Jeremiah Tuxin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Sopia Tilson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

MAY 18 1927

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to May 17, 1927, that I last saw her alive on May 17, 1927, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH was as follows:

Syphilis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R Lee Brady M. D.

, 19 (Address) Johns Hopkins Hospital Balto Md

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md Date of Burial May 18-27

20 UNDERTAKER David Easton ADDRESS Easton Md

Spec.—1-12-23—M&T—500 Bks.

E 22378 E 22378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

OK Jos Collier

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline ST., 9-17 WARD)

2-FULL NAME Percy Culver

(a) RESIDENCE NO. 1806. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Hattie H Culver

6 DATE OF BIRTH (month, day, and year) July 10 1883

7 AGE 43	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	44	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N. Y.

PARENTS

10 NAME OF FATHER William M. Culver

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Jessie Gillis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Hattie Culver (Address) 407 Warren Crescent Norfolk Va

15 Filed MAY 19 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1927 to May 18, 1927.

that I last saw him alive on May 18, 1927.

and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation,

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Clarence R. Monroe, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL May 18 1927

20 UNDERTAKER Robb & Turner Jr. — ADDRESS 1117 W Broadway

Spec.—1-10-21—M&T—1500 Blks.

E 22379

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22379

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 513 Collins Ave (St.) 20-71 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Monroe Shipley

(a) RESIDENCE NO. 513 Collins ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharyne Shipley

6 DATE OF BIRTH (month, day, and year) Jan 1 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	4	16	15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegrapher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg West Va

PARENTS

10 NAME OF FATHER Chas H. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Sarah C. Kerns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mrs J. M. Shipley (Address) 513 N. Collins Ave

15 Filed MAY 18 1927 F. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to May 16, 1927, that I last saw h.im alive on May 16, 1927, and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Meningitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George A. Wearn, M. D.

5/17 1927 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 18 1927

20 UNDERTAKER George J. Smith ADDRESS 153 Hollins

Spencerian Co.—200 Bks.

E 22380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22380

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 5-8 E. or W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie Miller

(a) RESIDENCE NO. 419 N. High st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Washington Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 27, to May 15, 19 27, that I last saw her alive on May 15, 19 27, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gallens, M. D.

5-16-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elizabeth City, N.C. Date of Burial May 18 1927

20 UNDERTAKER John W Henderson ADDRESS 1502 Fremont

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22381

CERTIFICATE OF DEATH.

146

REGISTERED NO. E 22381

1-PLACE OF DEATH ~~Grace H. Goltz~~ South Balto Gen Hosp

City of BALTIMORE: (No. Light St. St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace H. Foltz

(a) RESIDENCE NO. ~~2528~~ McElderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Feb 24, ~~1897~~ 1898

7 AGE: Years 29 | Months 7 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto Md

PARENTS

10 NAME OF FATHER John H. Hoefner

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Corlett

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant John E. Foltz

(Address) 2528 McElderry St

Filed MAY 18 1927 C. HAMPSON JONES, M. D. Registrar

Per R.F.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 5-16

17

I HEREBY CERTIFY, That I attended deceased from ~~5-5~~ 5-5, 1927, to 5-16, 1927,

that I last saw her alive on 5-16, 1927,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Gen septicaemia & peritonitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Post partum infection

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Wesson M. D.

, 19 (Address) 30 Balto Med Soc Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: May 1927

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 1534 Londale St

Key information: See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Goodhues ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22382 E 22382

CERTIFICATE OF DEATH.

2-4 14

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Broadway ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Goodhues

(a) RESIDENCE NO. 15 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdinand J. Goodhues

6 DATE OF BIRTH (month, day, and year) July 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles H. Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jerome Goodhues

(Address) 15 S. Broadway

15 Filed 8 1927 16 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 16, 1927.

that I last saw h[illegible] alive on May 16, 1927,

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman F. Guering, M. D.

May 17, 1927 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/19, 1927

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 503 N. Calvert

Spec.–7-17-26—A Co.—200 Bks.

E 22383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-001

E 22383

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1725 Homestead St. St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Merryman Trauty

(a) RESIDENCE NO. 1725 Homestead St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Trauty

6 DATE OF BIRTH (month, day, and year) Aug. 22, 190[illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	26	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemical works 26

(b) General nature of industry, business, or establishment in which employed (or employer) Chemical works

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Trauty Md.

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Alive Webb

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Lucille E Trauty

(Address) 1725 Homestead St

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1926, to May 16, 1927.

that I last saw him alive on May 16, 1927.

and that death occurred, on the date stated above, at 850 P. m.

The CAUSE OF DEATH* was as follows:

Aplastic Anaemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency,

(duration) yrs. mos. 8 ds.

18 Where was disease contracted

if not at place of death? Baltimore Md

Did an operation precede death? Yes Date of 5/31-26, 1/27, 2/8, 3/7, 4/9/27

Was there an autopsy? No

What test confirmed diagnosis? Hemmorrhage, inflammation

(Signed) Chas Cl[illegible]rald, M. D.

5/18, 1927 (Address) 227 Windsor Road, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	May 19/1927

20 UNDERTAKER John Ullrich ADDRESS 2008 Orleans St

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22384 129 E 22384

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3230 Elmley Ave. St., 8-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Stevens

(a) RESIDENCE NO. 3230 Elmley Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Darius W. Stevens

6 DATE OF BIRTH (month, day, and year) July 5, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	69	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known

(State or country)

14 Informant Lawrence C. Stevens

(Address) 3230 Elmley Ave.

15 Filed MAY 18 1927 Registrar

C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 16, 1927, that I last saw her alive on May 16, 1927, and that death occurred, on the date stated above, at 8:03 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B. Lemmon, M. D.

5/18, 1927 (Address) 718 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oak Lawn Cemetery	May 19 19
20 UNDERTAKER John Ulrich	ADDRESS 2008 Orleans.

John Ulrich

Very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

E 22385

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22385

CERTIFICATE OF DEATH.

REGISTERED NO. C 731

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Madison

(Residence in Baltimore: No. St. Elizabeths Home Chestnut Hill ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	negress	

6-DATE OF BIRTH, Foundling ....., 1 ..... (Month) (Day) (Year)

7-AGE, Foundling about ....yrs....7....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....W.D.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Probably Balto. Md

PARENTS.

10-NAME OF FATHER, Foundling

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Rec'd ....., 191.....

B 1927 C. HAMPSON JONES, M. D.

Per ..... Registrar.

1364

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 3 1927, to May 17 1927, that I saw her alive on May 17 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus (Opportunity of Tuberculosis Organism)

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) see supplement

(Duration) yrs. mos. ds.

(Signed) Francis J. Ayd M. D.

May 18, 1927 (Address) 2055 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

Health.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22386

CERTIFICATE OF DEATH.

E 22386

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. In way from 116 Light St to Emergency St. 11th Ward)

2-FULL NAME Henry C. Weber

(a) RESIDENCE NO. 112 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Anne Hafer

6 DATE OF BIRTH (month, day, and year) January 31 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69			

8 OCCUPATION OF DECEASER

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Henry C. Weber

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Carl G. Oldenmeyer

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Pearl Elizabeth Hafer

(Address) 3524 Gudwood Ave

15 Filed 19 C. HAMPSON JONES, M. D.

8 1927 By C.H.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed between Buffers

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

May 17, 1927 (Address) 1039 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial May 20 1927

20 UNDERTAKER Harry H. Almacost — ADDRESS 4704 Ridgewood Ave

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22387

CERTIFICATE OF DEATH

129 E 22387

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 S. ~~Ellwood~~ Lakewood ave St., 9-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Hunter

(a) RESIDENCE NO. 525 S ~~Ellwood~~ Lakewood ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Hunter

6 DATE OF BIRTH (month, day, and year) June 20. 18[illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	71	10	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer Curtis Shipbuilders

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Alexandra Hunter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Gertrude Hunter

(Address) 525 S Lakewood ave

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

Very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to May 17, 1927, that I last saw him alive on May 17, 1927, and that death occurred, on the date stated above, at 1 10 A m.

The CAUSE OF DEATH* was as follows:

Uremia Paraneophrotic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) yrs. mos. 3 ds.

18 Where was disease contracted Unknown

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopical

(Signed) C. H. Jones, M. D.

5/18, 1927 (Address) 5307 Belleview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cem	May 20 '27
20 UNDERTAKER	**ADDRESS**
Wendell S. Hippel	3004 Eden

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22388

CERTIFICATE OF DEATH.

91-2

E 22388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1139 Scott St. 21-29 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Tohe

(a) RESIDENCE NO. 1139 Scott ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 57 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretha Tohe.

6 DATE OF BIRTH (month, day, and year) Feb 17-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Piano 014

(c) Name of employer Knabe Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred. Tohe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Ose (Address) 1139 Scott St.

15 Filed MAY 19 1927 19 Per RK. C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927 to May 18. 1927

that I last saw h~~im~~ alive on May 17, 1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. Campbell M. D.

May 20, 1927 (Address) 1640 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 20 1927

20 UNDERTAKER ADDRESS

Mrs John H. Teufel 1201 N. Eutaw St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22389

CERTIFICATE OF DEATH.

129

E 22389

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2709 E. Monument St. (Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Pike

(a) RESIDENCE. No. 2709 E. Monument St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James I. Pike

6 DATE OF BIRTH (month, day, and year): Oct 1st 1857

7 AGE: Years 69 Months 7 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Richard Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary F. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Worcester Co Md

14 Informant: James Pike

(Address): 2709 E. Monument

15 Filed: 9 1927 C. HAMPSON JONES, M. D. Registrar

Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25 to May 18 1927.

that I last saw h[illegible] alive on May 17 1927.

and that death occurred, on the date stated above, at 6.55 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. Leland M. D.

May 19 1927 (Address) 2201 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: May 21st 1927

20 UNDERTAKER: H. Kunnecke

ADDRESS: 1004 Pennsylvania Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22390

CERTIFICATE OF DEATH.

E 22390

REGISTERED NO. 16-23

1-PLACE OF DEATH

City of BALTIMORE: (No. 1131 N Carey St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Pinckney

(a) RESIDENCE NO. 1131 N Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Mary Pinckney

6 DATE OF BIRTH (month, day, and year) Dec. 24-1866

7 AGE: Years 60 Months 4 Days 21 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Jos. Pinckney

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Eleanor Mille

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mary Pinckney (Wife)

(Address) 1131 N. Carey St. C

C. HAMPSON JONES, M. D.

15 Filed MAY 19 1927 By RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from March 29 1927 to May 16 1927

that I last saw h~~is~~ alive on May 16, 1927,

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia (non specific)

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wasserman

(Signed) H S McCaard, M. D.

5/18, 1927 (Address) 2005 Allendale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial May 19 1927

20 UNDERTAKER Jno. M. Johnson ADDRESS 1234 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

E 22391 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 2-4 Ward)

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Browning

(a) RESIDENCE NO. 510 S. Castle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. dy. How long in U. S., if of foreign birth? yrs. mos. dy.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE: Years 56 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel T. Browning

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mass

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

MAY 19 1927

C. HAMPSON JONES, M. D. Registrar

Reg. RK 7

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to May 17, 1927, that I last saw him alive on May 17, 1927, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic & Acute Alcoholism

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Laboratory

(Signed) C. Hooper Pinell, M. D.

May 19 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: May 20 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22392

100-001

E 22392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 15-56 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Tucker

(a) RESIDENCE NO. 2606 Keyworth Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single ?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wesley Tucker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Margaret Hancock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) A. A. Co. Md

14 Informant

(Address) [redacted] Record

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

BALTIMORE CITY HOSPITALS

MAY 17 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to May 17, 1927, that I last saw h.. alive on May 16, 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Senility
Contd Abscess

(duration) .....yrs. .....mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) .....yrs. .....mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & Laboratory

(Signed) [redacted] M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial: May 19 1927

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light St

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22393

101-006

E 22393

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. East City Hospital St. 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Walchuk

(a) RESIDENCE NO. 931 East Baynes St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1882.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	45	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Shipbuilding Co.

9 BIRTHPLACE (city or town) Austria

(State or country)

PARENTS

10 NAME OF FATHER Frank Walchuk

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Katie

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Austria

14 Informant Baltimore Hospl

(Address) Edmondson

15 Filed 19 Registrar

MAY 19 1927 C. HAMPSON JONES Jr. D.

Plat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-30-27, to 5-17-27, 19

that I last saw h... alive on 5-17-27, 19

and that death occurred, on the date stated above, at 9 05 P.M.

The CAUSE OF DEATH* was as follows:

Empyema Left

pleural cavity

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? At Home

Did an operation precede death? Yes Date of 1-31-27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Edwin M. Robertson M. D.

19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery

Date of Burial May 20 1927.

20 UNDERTAKER Mr. August Pasedach

ADDRESS Eastland Ave.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22394

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 E Lombard St St. 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard M. Radziewicz

(a) RESIDENCE NO. 1818 E Lombard St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Radziewicz

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Blachowicz

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant John Radziewicz
(Address) 1818 E Lombard St

15 Filed MAY 19 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1927, to 5/18, 1927, that I last saw h[illegible] alive on 5/17, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Ac bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) David Thomas, M. D.

, 19 27 (Address) 3325 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: May 20 1927

20 UNDERTAKER: George A. Weber — ADDRESS: 2205 Bank St

IF NOT very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Demek

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22395 E 22395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1708 Patapsco ST. 73-34 WARD)

REGISTERED NO. 11001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Demek

(a) RESIDENCE NO. 1708 Patapsco ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Martin J Demek

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna M Stumpf

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Martin J Demek
(Address) 1708 Patapsco St

15 Filed MAY 19 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 17, 1927, that I last saw her alive on May 17, 1927, and that death occurred, on the date stated above, at 8 40 mP

The CAUSE OF DEATH* was as follows:

Acute Congestion of Lung

(duration) yrs. mos 1 day

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alf S Gogl M. D.

5/18/27 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co

DATE OF BURIAL 5-20 1927

UNDERTAKER Earle Harle

ADDRESS 115 E West St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22396

E 22396

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3863 Monastery Ave St. 20-21 Ward

2-FULL NAME Phillipp Bopp

(a) RESIDENCE NO. 3863 Monastery Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Bopp

6 DATE OF BIRTH (month, day, and year) Nov 23 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Locke Insulator Corp

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Ambrose Bopp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Otterbein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant August H. Bopp Jr.

(Address) 3838 Culver St

15 Filed MAY 19 1927 HAMPSON JONES, M. D. Registrar

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by Inquest and Autopsy find that said deceased came to h... death as stated

(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Dead when found

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY

(Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

May 18-1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Co. Date of Burial 5-21 1927

UNDERTAKER E. T. Burke Co. ADDRESS 115 E. Hoffman St

Very important. See instructions on back of certificate.

Sobczynski

Spec.–7-17-26—A Co.—200 Bks.

E 22397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 22397

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 412 So. Dallas St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sobczynski,

(a) RESIDENCE NO. 412 So. Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 38 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elazebeth Sobczynska,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min..
	58	XXX		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?????

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Elazebeth Sobczynska,

(Address) 412 So. Dallas Street

15 Filed ... 19 ... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16- 1927.

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1927, to 5/15, 1927.

that I last saw him alive on 5/15 1927

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Heart failure & collapse

(duration) ... yrs. ... mos. 1 da.

18 Where was disease contracted

if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Thos A Q autopsy, M. D.

, 19 (Address) 1613 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery — Date of Burial 5/19/27, 19

20 UNDERTAKER M. J. Sadowski — ADDRESS 705 S. Ann St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 22398 HEALTH DEPARTMENT—CITY OF BALTIMORE 154 E 22398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 South Paca ST. 71-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Brazis

(a) RESIDENCE No. 926 South Paca ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) May 9. 1927

7 AGE — Years — Months — Days 9 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Brazis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Dulckis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Joseph Brazis (Address) 926 S Paca Street

15 Filed MAY 19 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9. 1927 to May 18. 1927 that I last saw him alive on May 18. 1927 and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Pemphigus Neonatorum

(dutation) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Noble Clarkowshy M. D.

5/19. 1927 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL May 19. 1927

20 UNDERTAKER John Grebliauckas ADDRESS J. G. 423 S. Paca St

Spec.—1-10-21—M&T—1500 Bks.

Zwoontz

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22399 E 22399

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 10 N Washington ST. 6-9 (WARD)

2-FULL NAME Nathan Zwoontz

(a) RESIDENCE NO. 10 N Washington ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Zwoontz

6 DATE OF BIRTH (month, day, and year) January

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A Zwoontz

(Address) 10 N Washington St

Filed MAY 19 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-13, 1927, to 5/19, 1927, that I last saw him alive on 5/18, 1927, and that death occurred, on the date stated above, at 10 9 m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Hemiplegia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Maurice Rhodeen M. D.

, 19 (Address) 2220 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebrew Rosedale — DATE OF BURIAL 5/19 1927

20 UNDERTAKER Jacob Lewis — ADDRESS 1439 E Balt St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22400 E 22400

CERTIFICATE OF DEATH.

REGISTERED NO. 100-031

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4106 Belair Road ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Vertel

(a) RESIDENCE NO. 4106 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late John Vertel

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) James R. Stoverman 4106 Belair Road

15 Filed 19 1927 C. HAMPSON JONES, M. D. Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 17, 1927, that I last saw her alive on May 17, 1927 and that death occurred, on the date stated above, at 835a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs 7 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. A. Kuebler M. D.

19 (Address) 4 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL 5/20/1927

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Spec.—1-12-23—M&T—500 Bks.

E 22401

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22401

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Robert ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wright

(a) RESIDENCE NO. 524 Robert ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Warrenton Ga

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Unknown

14 Informant: Blanche Wynn

(Address) 524 Robert St

Filed MAY 19 1927 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17 1927

17

I HEREBY CERTIFY, That I attended deceased from 1/10, 1927, to 5/17, 1927,

that I last saw h alive on 5/17, 1927

and that death occurred, on the date stated above, at 9 45 A.M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I B McCutcheon, M. D.

5/18, 1927 (Address) 213 D St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 5/19 1927

20 UNDERTAKER: Samuel H Handy

ADDRESS: Balto

Spec.—1-10-21—M&T—1500 Bks.

E 22402

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22402

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2756 N. Lafayette ave ST. 16-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Volk

(a) RESIDENCE NO. 2756 N. Lafayette ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 17-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of Industry, business, or establishment in which employed (or employer) Home 069

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Volk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Virginia Whaley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. John Murphy
(Address) 2756 N. Lafayette ave

15 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 8 . 1927 . to May 17 . 1927 .

that I last saw h alive on May 16 . 1927

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jane Thomas, M. D.

May 17. 1927 (Address) 1837 Penna. ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL May 20 1927

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22403 E 22403

CERTIFICATE OF DEATH.

REGISTERED NO. 77-43

1-PLACE OF DEATH

City of BALTIMORE: (No. 24 Clemmore Av St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Bontrum

(a) RESIDENCE NO. 24 Clemmore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Bontrum

6 DATE OF BIRTH (month, day, and year): Jan 26 1852

7 AGE: Years 75 | Months 3 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commercial cultivation

(b) General nature of industry, business, or establishment in which employed (or employer): Department in store Fishing Tackle Manufacturing

(c) Name of employer: Clement & Ball

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Peter Bontrum

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant: Sarah H. Bontrum

(Address) 24 Clemmore Ave

15 C. HAMPSON JONES, M. D. Registrar

9 1927 Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1926, to May 18, 1927, that I last saw ~~him~~ alive on May 18, 1927, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M L Gatt, M. D.

5/18/1927 (Address) 1119 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem Date of Burial May 21 1927

20 UNDERTAKER: Tallman Corp ADDRESS 305 E North Ave

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22404

CERTIFICATE OF DEATH.

E 22404

101-004

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 Canal alley St., 11-24 Ward)

2-FULL NAME James Cardy

(a) RESIDENCE NO. 310 Canal alley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant W. W. Dick Cook

(Address) Penna Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

Rec. 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) no other known

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

19 27 (Address) 1802 Edmondson Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

MAY 19 1927

Very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 22405 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland Penitentiary St., Forfeit Ward. Registered No. 9227

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cure

(a) Residence No. 767 Cherry St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Mar. 1-1899

7-AGE. 28 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, George Cure

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER, Hattie Tyles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Md.

14-

(Informant) Md. Penitentiary

(Address) 954 Forest St.

15- 9 1927 1369 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15, 1927

17- I HEREBY CERTIFY, That I attended deceased from March 16, 1927 to May 15, 1927

that I last saw h... alive on May 15, 1927

and that death occurred, on the date stated above, at 6 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L. Anderson M. D.

5/15, 1927 (Address) Md. Penitentiary

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 1927

20-UNDERTAKER. ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 22406

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22406

CERTIFICATE OF DEATH.

163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 843 N. Ostend St. 21-29 Ward)

2-FULL NAME Not named

(a) RESIDENCE NO. 843 N. Ostend St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col'd	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8/1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Harvey Wells

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ethel Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Ethel Green

(Address) 843 N. Ostend St

Filed 1370 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 9 — 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Investigation find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Born Alive after birth Mother said Child on Ground on vacant lot - Died from Exposure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

May 17 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22407

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22407

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5-8 ST., WARD)

2-FULL NAME Tom Winn

(a) RESIDENCE NO. 710 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1917

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1917 to May 9, 1917

that I last saw him alive on May 9, 1917

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Hendrix M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant
(Address) C. HAMPSON JONES M.D.

15 Filed MAY 19 1927, 19 RRH Registrar

1371

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

REGISTRAR OF VITAL STATISTICS OF MARYLAND
Commissioner Health.
MAY 19 1927

Spec.—1-12-23—M&T—500 Bks.

E 22408

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22408

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 N. Linwood Ave. WARD 8-11)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry J. Weaver.

(a) RESIDENCE NO. 1239 N Linwood ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A.

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Allan E. Weaver

(Address) 101 Newberg or Estate of the Deceased

15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1927, to May 18, 1927, that I last saw him alive on May 18, 1927, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) John [illegible] M. D.

5-19-1927 (Address) 9045 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 20 1927

20 UNDERTAKER F. A. Richardson — ADDRESS 703 Hanover

Spec.—1-12-23—M&T—500 Bks.

E 22409 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22409

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 20-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Quigley

(a) RESIDENCE NO. 31 Augusta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Quigley

6 DATE OF BIRTH (month, day, and year) Jan 3, 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Instrument maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Quigley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Woodburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ella Quigley

(Address) 31 Augusta Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-19- 1927 to 5-17 1927

that I last saw him alive on 5-17 1927

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical findings

(Signed) WPQuigley M. D.

1927 (Address) Ct Eger Baptist

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 20 1927

20 UNDERTAKER Margaret E. Flynn

ADDRESS 14 W Lexington St.

Cor.—1-12-23—M&T—100 Bks.

E 22410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 22410

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St., 32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joel H. Drummond

(a) RESIDENCE NO 106 Rochester Pl. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lana G. Drummond

6 DATE OF BIRTH (month, day, and year): July 10-1876

7 AGE: Years 50 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Machinist
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas

10 NAME OF FATHER: Dortsmon

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

Informant: Lana G. Drummond
(Address): 106 Rochester Pl.

Filed 9 1927, 192 G. HAMPSON JONES, M. D. Registrar

PHY

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)

5/18, 1927 (Address) 632 Reliance

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL 5/20/1927

20 UNDERTAKER: J. J. Moran ADDRESS 3300 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 22411

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22411

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 S. Decker Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Apicella.

(a) RESIDENCE NO. 605 S Decker Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11 Sept 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Apicella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Livolsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Pulvirenti

(Address) 166 S Potomac St

15 9 1927 16 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1926 to May 17 1927.

that I last saw h er alive on May 17 1927.

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Ephendroin

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of spine

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) A. Palmisano M. D.

, 19 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 20th 19 27

20 UNDERTAKER Frank A Petrone

ADDRESS E. Pratt St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22412

CERTIFICATE OF DEATH.

155

E 22412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 6-4 WARD)

2-FULL NAME Solomon Katz

(a) RESIDENCE NO. 9 Irving Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Rubin Lesin

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Emma Lieberman

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Mrs Anna Katz (Address) 9 Irving Place

15 Filed MAY 20 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-17, 1927, to 5-19, 1927, that I last saw him alive on 5-19, 1927, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis (Streptococcic.)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes. Date of 5-19-27

Was there an autopsy? no

What test confirmed diagnosis? clinical & Laboratory

(Signed) A. S. Knapp. M. D.

5-19, 1927 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rod. Cemetery DATE OF BURIAL 5/20 1927

20 UNDERTAKER D. Jack Levin ADDRESS 1439 Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22413

CERTIFICATE OF DEATH.

78 E 22413

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 126 S. Edenwood St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rubin Mazer

(a) RESIDENCE NO. 126 S. Edenwood St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Michael Mazer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Ella Fine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Matthew Mazer

(Address) 1900 E Baltimore St

15 Filed..... 19 ..... Registrar

NOV 20 1927 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

(Signed) A. C. Fiske M. D.

(Coroner)

May 19 27 (Address) 143 E Pray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Rosh Rd	5/20 1927

20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 22414

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 ✓ E 22414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 27-56 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Katie Steller

(a) RESIDENCE NO. 23 E Woodlawn St. Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colin

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jack Steller

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 30 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town): —

(State or country): England

PARENTS

10 NAME OF FATHER: — Rosenberg

11 BIRTHPLACE OF FATHER (city or town): —

(State or country): England

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country): —

14 Informant: Jack Steller

(Address): 23 Woodlawn Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day Stated above.

The CAUSE OF DEATH was as follows:

Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis Pregnancy 7½ months (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Waller M. D.

(Coroner)

5/18/27 (Address) 508 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cem. Date of Burial 5/20 19 27

20 UNDERTAKER: Jack Lewis ADDRESS 1395 E Baltimore

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22415 — 12-50 — 90 — E 22415

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 427 East 23 St., 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Wesley Green

(a) Residence No. 427 East 23 St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Bertha Green

6-DATE OF BIRTH (month, day and year): 1890 estimated

7-AGE: 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.
10-NAME OF FATHER: Robt Green
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Cornelia Clark
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Robt Green
(Address): 427 East 23 St.

15- MAY 20 1927 — C. HAMPTON JONES, M. D. — Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 17, 1927

17- I HEREBY CERTIFY, That I attended deceased from May 12 1927 to May 16 1927 that I last saw h[illegible] alive on May 16 1927 and that death occurred, on the date stated above, at 8:45 a.m.

THE CAUSE OF DEATH* was as follows: Organic Heart Disease

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Ex.

(Signed) Garland Hamilton M D
, 19 (Address) 1534 East Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 20, 1927

20-UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1727 Eastlundale

instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22416

CERTIFICATE OF DEATH

90 E 22416

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Conquest

(a) RESIDENCE NO. Balto City Hospital St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE: Years 72 Months Days

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Estelle Seymour

(Address) 702 N. Eutaw St.

15 Filed MAY 20 1927, 19

C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1927, to May 18, 1927

that I last saw him alive on May 18, 1927

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Generalized Osteosclerosis

Chronic Myocarditis,

Senile Gangrene Left foot

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 12, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Path Report.

(Signed) W. B. Angevine, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

Date of Burial 5/20 1927

20 UNDERTAKER Samuel A. Bruley

ADDRESS Balto

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22417

CERTIFICATE OF DEATH.

31 E 22417

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 E Madison St. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Wilson

(a) RESIDENCE NO. 1742 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Oscar Wilson

6 DATE OF BIRTH (month, day, and year) Nov 4 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Georginia Bundy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant Nora Henson (Sister)

(Address) 1742 Madison St

MAY 20 1921

H. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927 to May 19 1927 that I last saw h alive on May 19 1927 and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 002

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

5/19 1927 (Address) 1729 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery May

DATE OF BURIAL 22 1927

20 UNDERTAKER Walter Davis 316 N Eden St

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22418 — CERTIFICATE OF DEATH. — 31 — E 22418

1-PLACE OF DEATH 3020 Presstman St. REGISTERED NO. 16-67

CITY OF BALTIMORE: (No. 3020 Presstman ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Poole

(a) RESIDENCE NO. 3020 Presstman St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of: T Howard Poole.

6 DATE OF BIRTH (month, day, and year): 9-16-1864

7 AGE — Years: 62 — Months: 8 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 0.37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Ady.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co.

12 MAIDEN NAME OF MOTHER: Laura Eichelberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore.

14 Informant: Miss Minnie Ann (Address) 3020 Presstman St

15 Filed 20 1927. 19 Per RH. Registrar — C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to May 19, 1927, that I last saw her alive on May 18, 1927, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas O'Donnell M. D.

May 18, 1927 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hickory (Harford Co) — DATE OF BURIAL: 5-21-27.

20 UNDERTAKER: Martin Eckert & Sons — ADDRESS: 1827 N York St.

Spec.—12-9-25—A Co.—200 Bks.

E 22419

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 22419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 22-33 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Childs

(a) RESIDENCE NO. 24 Church St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) S. Carolina

PARENTS

10 NAME OF FATHER Ann Childs

11 BIRTHPLACE OF FATHER (city or town):

(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) S. Carolina

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

Filed 20 1927 19 C. HAMILTON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1927.

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 18, 1927

that I last saw him alive on May 18, 1927

and that death occurred, on the date stated above, at 2.00 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic & acute

Arteriosclerosis

Hypertension

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Lab

(Signed) C. Hamilton Jones M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary May 20 1927

20 UNDERTAKER: R L Parham ADDRESS: 1216 S Sharp St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22420 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 - E 22420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2611 Belair Ave (St.) 8-40 (Ward)

2-FULL NAME Estella Heinze

(a) RESIDENCE NO. 2611 13 East ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Heinze

6 DATE OF BIRTH (month, day, and year): Aug 9-1880

7 AGE: 46 Years | 9 Months | 10 Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Elizabeth Kimberin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Charles Heinze

(Address) 2611 Belair Ave

15 Filed MAY 20 1927 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926, to May 19, 1927.

that I last saw h alive on May 19 1927

and that death occurred, on the date stated above, at 9.45 P.M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw D Jones M. D.

May 21 (Address) Cor Fort & Bowley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: May 23 1927

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1739 E. Eager

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22421

CERTIFICATE OF DEATH.

REGISTERED NO. E 22421

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Harry Franck

(a) RESIDENCE NO. 1441 Light St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of)))))

6 DATE OF BIRTH (month, day, and year) Oct 7/26

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Arthur M. Franck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Nina Toomey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Arthur M. Franck

(Address) 1441 Light St

15 Filed 19

Registrar

MAY 20 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Streptococcic Septicemia. (Infection thru cervical glands. Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Packer M. D.

(Coroner)

5/20/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Date of Burial May 20 1927

20 UNDERTAKER D. Kenn McCully ADDRESS 1918 E. Fort Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22422
1-PLACE OF DEATH

90 E 22422
REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Rebecca Rosenfeld

(a) RESIDENCE NO. Sinai Hospital old Folks Home St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby. 19, 1857

7 AGE: Years 70 | Months 3 | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS
10 NAME OF FATHER Abraham Rosenfeld
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Henrietta —
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Adler.
(Address) Sinai Aged Home.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar
MAY 20 1927
Ref. LA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/1/ 1927, to 5/19/ 1927, that I last saw h[illegible] alive on 5/19/ 1927, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:
Hypertension Cardiovascular Disease.

(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 6 ds.

18 Where was disease contracted —
If not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John A. Arnold, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bal. Hebrew Cem. Date of Burial 5/20/ 1927

20 UNDERTAKER: Edward Sondheim ADDRESS 118 20th St. Royal Ave.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22423

45 E 22423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Caroline & Eden (St.) 8-17 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Rea.

(a) RESIDENCE NO. 1624 N. Bond ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Rea

6 DATE OF BIRTH (month, day, and year): Jan 6th 1862

7 AGE: Years 65 | Months 4 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ann Canton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mary Rea

(Address) Plymouth Hotel Ocean City Md

Filed MAY 20 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to May 18, 1927,

that I last saw her alive on May 18, 1927

and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clement R. Thomas, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/21/27

UNDERTAKER: Chas R. Traub & Son

ADDRESS: 1180 W. Royal Place

Spec.—12-9-25—A Co.—200 Bks.

E 22424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

E 22424

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3226 E. Lombard St., 16-2 Ward)

2-FULL NAME Joseph Ahl

(a) RESIDENCE NO. 3226 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: late Emma Ahl

6 DATE OF BIRTH (month, day, and year): May 3/57

7 AGE — Years: 70 — Months: — — Days: 14 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer): Sparrows Pt.

(c) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country)

PARENTS

10 NAME OF FATHER: Henry Ahl

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Susan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Scotland

14 Informant: Howard G. Ahl

(Address): 3226 E. Lombard

15 Filed: 20 1927 — C. HAMPSON JONES, M. D. Registrar — Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17/27

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to May 17, 1927, that I last saw him alive on May 17, 1927, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Esophagus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) [illegible], M. D.

, 19 (Address) 3015 Elwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 5/20 1927

20 UNDERTAKER: Philip Herwig — ADDRESS: Athens Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 22425 2148

× 58-001

E 22425

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ash

(a) RESIDENCE NO. 28 Oak Ave - Pikesville Ward Shermans Dist Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Ash

6 DATE OF BIRTH (month, day, and year) Feby 20, 1843

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	83	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper 206

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Victor Ash

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Josephine —

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 20 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17

I HEREBY CERTIFY, That I attended deceased from April 15 1927, to May 18, 1927, that I last saw him alive on May 18, 1927, and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Aplastic Anaemia.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Hematological study

(Signed) Chas. H. Peters, M. D.

. 19 (Address) Johns Hopkins Hosp. Bal.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

Date of Burial 5/21 1927

UNDERTAKER Geo. Cook

ADDRESS 502 E. Mont. Ave.

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Dr Yost, 5600 York Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22426 | CERTIFICATE OF DEATH | E 22426

1-PLACE OF DEATH | REGISTERED NO.

City of BALTIMORE: (No. 5614 Pratt Ave. St. Govans 27-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian German

(a) RESIDENCE NO. 5614 Pratt Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 2. 1847

7 AGE: Years 79 | Months 6 | Days 16 | IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town):

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph German

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Ann Lowder

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: J. Oscar German

(Address): 5614 Pratt Ave

C. HAMILTON JONES, M. D.

15 Filed MAY 20 1927, 19

Per H H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 1927 to May 18 1927

that I last saw h— alive on May 18 1927

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. 16 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Yost, M. D.

5-19. 1927 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | Date of Burial: May 20 1927

20 UNDERTAKER: J. H. Cook | ADDRESS: 501 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Hesser 1301 Pat Pk Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22427

90 E 22427

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 Oakly St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D Bushey

(a) RESIDENCE NO. 206 Oakly St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J Bushey

6 DATE OF BIRTH (month, day, and year) March 19, 1871

7 AGE Years 56 Months 2 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew J Bushey

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Charles Bushey (Address) 206 Oakly

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927 to May 19, 1927.

that I last saw h[illegible] alive on May 19, 1927.

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Bulbar & Respiratory Paralysis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Thyroid Injection

(Signed) [illegible] M. D.

May 19 1927 (Address) 1301 Pat Pk Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial May 21 1927

20 UNDERTAKER [illegible] ADDRESS 502 E Oakly

HAMPDEN [illegible] M

MAY 20 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Carman 1701 N Carolina st

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 22428

CERTIFICATE OF DEATH

E 22428

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 Holbrook St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kay

(a) RESIDENCE NO. 1612 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Kay

6 DATE OF BIRTH (month, day, and year): Jan 8. 1862

7 AGE: Years 65 Months 4 Days 11

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: P. R. R.

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: James Kay

11 BIRTHPLACE OF FATHER (City or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: Emma Cuddy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Sarah Kay

(Address) 1612 Holbrook St

C. HAMILTON JONES, M. D.

15 Filed MAY 20 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1926, to May 19, 1927, that I last saw him alive on May 19, 1927, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + High Blood Pressure

Partial Left Hemaplegia, Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza Pneumonia - Central Pneumonia

+ Nephritis (duration) ? yrs. mos. da.

18 Where was disease contracted unknown

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Analysis

(Signed) C. H. Carman, M. D.

5 19. 1927 (Address) 1701 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Vernon M. E. Dalto Co — Date of Burial: May 21 1927

20 UNDERTAKER: W. M. Cook — ADDRESS 500 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 22429

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp. St. 18-16 Ward)

Registered No. 15001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hilda Gregory

(a) Residence No. 413 N. Bappleton St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, Divorced (write the word.) ~~Married~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 28 1923

7-AGE. 3 yrs. 5 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. no

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER James Gregory

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER Allie Boyd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Allie Gregory

(Address) 413 N. Bappleton St.

15- Filed ..... 192 C. HAMPSON JONES, M. D. Registrar.

MAY 20 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 19, 1927

17- I HEREBY CERTIFY, That I attended deceased from May 12, 1927 to May 19, 1927.

that I last saw her alive on May 18, 1927.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Rachitis, Hydrocephalus and Malnutrition

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Hilda Gregory M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. May 20th 1927

20-UNDERTAKER. Hamel Eastern ADDRESS 916 E 9 Ave.

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

(Mary J Splain)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22430 — E 22430

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH St Josephs Hosp.

CITY OF BALTIMORE: (No.) Caroline & Eden ST. 1-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Splain

(a) RESIDENCE No. 904 N Patterson Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis Splain

6 DATE OF BIRTH (month, day, and year) May. 1865

7 AGE — Years 62 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Horan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Foley

13 BIRTHPLACE OF MOTHER (city or town) " "

(State or country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May. 16 1927, 19 to May. 18 1927, 19, that I last saw h alive on May. 18 1927, 19, and that death occurred, on the date stated above, at 2 am m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? >

Did an operation precede death? yes Date of May. 17. 27

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Clement A. Thomas, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Dennis Splain

(Address) 904 N Patterson Park Ave

15 C. HAMPSON JONES, M. D. Registrar

MAY 20 1927 By RRK

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral

DATE OF BURIAL May 21 1927

20 UNDERTAKER Geo M. Smith & Son

ADDRESS Baltimore

Print clearly and important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22431 — 188-003 — E 22431

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: City of BALTIMORE: (No. Pronounced dead at St. Joseph Hospital St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Chester ~~Sherlee~~ Lee Smith

(a) RESIDENCE NO. 1121 N. Bradford St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) April 17. 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer): ob

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Harvey M. Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frederick Co. Pa

12 MAIDEN NAME OF MOTHER Clara A. Beans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Harvey M Smith

(Address) 1121 N. Bradford St

MAY 20 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Shot

Crushed head - run over by autotruck

1000 block N. Milton Ave

Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Beans M. D.

(Coroner)

5/20/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — Date of Burial: May 24 27

20 UNDERTAKER: [illegible] — ADDRESS: 200 Orleans

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

~~STILL BIRTH~~ 17242

STATE OF MARYLAND

1 PLACE OF DEATH
E 22432

E 22432 CERTIFICATE OF DEATH

County

Registration Dist. No. 161001

Village or City Baltimore (No. 3611 Fait ave St.; or Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dorothy Overlander

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 18 (Day) 1927 (Year)

7 AGE: yrs. mos. ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: NO
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Overlander

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Dorothy Remisch

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Overlander

(Address) 3611 Fait ave

15 Filed MAY 26 1927, 191 C. HAMPSON JONES M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 18 (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1927 to May 18, 1927, that I last saw h~~e~~ alive on May 18, 1927, and that death occurred on the date stated above at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
1 month Fatus

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) O'Brien M.D. M.D.

5/19, 1927 (Address) 315 S. Highland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs mos ds In the State yrs mos ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Volrno Hopkins Expt

DATE OF BURIAL: 5-17-1927

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

SECTION 11 OF LAW VERY IMPORTANT. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

*E 22433

CERTIFICATE OF DEATH.

185 E 22433

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Czajkowski.

(a) RESIDENCE NO. 2706 Dillon St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) June 11, 1900.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Bernard Czajkowski.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Catherine Czajkowski.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Bernard Czajkowski. (father)

(Address) 2706 Dillon St.

MAY 20 1927 HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of Perinaeum into rectum, Hemorrhage, shock. Accidental fall on to the end of a pipe protruding in a manhl. ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto Steinhardt M. D. (Coroner)

5/18 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Codge Forest, Balto. Co. May 18, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial May 21 1927

20 UNDERTAKER Stephen Falkowski ADDRESS 1178 Spring

Per

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is necessary, so that it may be properly classified. Exact statement of CAUSE

Spec.—1-12-23—M&T—500 Bks.

E 22434

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22434

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 n. Dallas ST., 8-17 WARD)

2-FULL NAME Zelma Council

(a) RESIDENCE NO. 1512 n. Dallas ST., WARD Cambridge md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10. 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge
(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Elliott

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jane Council

13 BIRTHPLACE OF MOTHER (city or town) Cambridge
(State or country) Md.

14 Informant Nazarine Council
(Address) 1512 n. Dallas

15 0 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 18, 1927, that I last saw h[illegible] alive on May 18, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Cancer)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Obs.

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	May 21 1927
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Caroline St.

Spec.-7-17-26—A Co.—200 Bks.

E 22435

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22435

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. Caroline & Oliver St. Ward) 9-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Fletcher Dryden Jr.

(a) RESIDENCE NO. Champ Sommerset Co. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 23 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	28	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Sommerset Co. Md.

PARENTS

10 NAME OF FATHER Elmer F. Dryden

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Virginia. Parks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Mrs. Walter C. Hudson

(Address) 1765 Montpelier St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927 to May 19 1927

that I last saw him alive on May 19 1927

and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Chr. Mastoid.

lateral Sinus Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation preeede death? yes Date of May 7 1927

Was there an autopsy? No.

What test confirmed diagnosis? clinical

(Signed) H. R. McCarrell M. D.

19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cem.	May 21 1927
20 UNDERTAKER Wm J Tucker & Sons	ADDRESS Norfolk Va

Be certain all parts are filled in, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22436

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22436

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH Franklin Square Hospl. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 21 WARD)

2-FULL NAME George Becker

(a) RESIDENCE NO. 181 Carroll St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Margaret Becker

6 DATE OF BIRTH (month, day, and year): March 22-1845

7 AGE: Years 82 (82) Months 1 Days ~~27~~ 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Margaret Becker 181 Carroll St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12th, 1927, to May 19th, 1927, that I last saw h[illegible] alive on ....., 19..., and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Hypertatic Anemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Gangrene

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/13/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) William Walker M. D.

, 19 (Address) Franklin Square Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 21-27

20 UNDERTAKER: W. J. Fuchs & Son — ADDRESS: Pennsylvania Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22437

E 22437

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Dolphin St. ST. 11-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William John Unverzagt

(a) RESIDENCE NO. 309 Dolphin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philomena D Unverzagt

6 DATE OF BIRTH (month, day, and year) Feby. 8.1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Agents

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Casualty Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George A. Unverzagt

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Cronhardt

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Wm. J. Unverzagt

(Address) 309 Dolphin St.

15 Filed 20 1927, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 18, 1927, that I last saw him alive on May 17, 1927, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Sudden (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam.

(Signed) [illegible], M. D.

5/19, 1927 (Address) Ridge Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 21 1927

20 UNDERTAKER: Wm. J. Tickner & Sons

ADDRESS: NorthAve

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 22438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22438

CERTIFICATE OF DEATH.

REGISTERED NO. 15-2390

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Stevens

(a) RESIDENCE NO. 1351 W Cary St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) 769

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Arthur Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Jennie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed ..... 19 ..... Registrar

C. LAMPSON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to May 19, 1927

that I last saw her alive on May 19, 1927,

and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

a Cute.

Cutaneous Uremia

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Local

(Signed) C. Holmes Boyd M. D.

, 19 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial May 21 1927

20 UNDERTAKER Harmon & Albrecht ADDRESS 1364 W Cary

Very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 22439 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 22439

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) 1913 N. Collington St. WARD 20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regina Dent

(a) RESIDENCE NO. 1913 N. Collington ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	9	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Randolph Dent

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Frances Simmonds

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) City

14 Informant Frances Dent
(Address) 1913 N. Collington St.

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. ... ds.

(Signed) Harris A. Fisher M. D.
(Coroner.)

, 192 (Address) 332 S. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... DATE OF BURIAL May 23 1927

UNDERTAKER Samuel Wright ADDRESS 644 Cary

MAY 20 1927 C. HAMPSON JONES Registrar

FOR IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22440

E 22440

CERTIFICATE OF DEATH.

+4

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Central ave ST., (5-8 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Katz

(a) RESIDENCE No. 616 N Central ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Rachael Katz

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Louis
(Address): 1439 E Baltimore St

15 5 20 1927 C. HAMPSON JONES, M. D., Registrar.
Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/20 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927 to May 19 1927.

that I last saw him alive on May 18, 1927.

and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 2 mos 1 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory tests

(Signed) Samuel Silverstein M. D.

, 19 (Address) 27 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 5/20 1927

20 UNDERTAKER: Jack Louis

ADDRESS: 1439 E Baltimore St

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 22441

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22441

CERTIFICATE OF DEATH

31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 5-7-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmit Faulkner

(a) RESIDENCE NO. 618 W. Lanvale st. St. Ward

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry cleaning

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Baily Faulkner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed MAY 20 1927 C. HAMPSON JONES, M. D. Registrar

Per RRB

1375

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 3, 19 27, to May 16, 19 27,

that I last saw him alive on May 16, 19 27,

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gallens M. D.

5-17-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial MAY 20 1927

20 UNDERTAKER

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22442

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22442

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hosp St. 16-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis McAbee

(a) RESIDENCE NO. 843 Robson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: 75 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER ~~Unknown~~

11 BIRTHPLACE OF FATHER (City or town):

(State or country) U S

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant

(Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

20 1927 1376

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1927, to May 16, 1927, that I last saw him alive on May 16, 1927 and that death occurred, on the date stated above, at 4:00 p. m.

The CAUSE OF DEATH* was as follows: Cardiac Syncope Lues Aortic Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical & Laboratory

(Signed) W. Reeves, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial MAY 20 1927

20 UNDERTAKER: ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

Asst. Wm. S. GUBRALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22443

CERTIFICATE OF DEATH

100-901

E 22443

1-PLACE OF DEATH Balto City Hospt

City of BALTIMORE: (No. Balto Md St. 1637 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wolmack

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5 - 19 - 27

17

I HEREBY CERTIFY, That I attended deceased from 7-20-, 1926 to 5-19-, 1927

that I last saw him alive on 5-16-, 1927

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis - Senile Epilepsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry [illegible] M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

MAY 20 1927

Health Department

0 1927 Pc 1377 RCN

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 22444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 22444

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 McCurley St 26-70 Ward)

2-FULL NAME Julius C. Litzau

(a) RESIDENCE NO. 30 McCurley St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 45 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Litzau

6 DATE OF BIRTH (month, day, and year): aug 19, 1854

7 AGE: Years 72 | Months 9 | Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): _____

(State or country): Germany

PARENTS

10 NAME OF FATHER: Carl Litzau

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Erstine Nau

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Germany

14 Informant: Theresa Litzau

(Address): 30 Mc Curley St.

15 Filed _____ 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1927 to May 18, 1927

that I last saw h[illegible] alive on May 18, 1927

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Uterine adenocarcinoma, Left hemiplegia

(duration) 5 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Findings of Surgery

(Signed) [illegible], M. D.

, 19 (Address) 33 W. Fredericktown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: May 21, 1927

20 UNDERTAKER: Chas. W. Dill ADDRESS: 1409 Fredk. Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

(Chas. H. Sellman)

E 22445

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sellman Chas H.

(a) RESIDENCE NO. Davidsonville, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed 20 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 20, 1927

that I last saw him alive on May 20, 1927,

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 15? yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E K Miller, M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camp Parole Md — DATE OF BURIAL 5-20, 1927

20 UNDERTAKER James J Cox — ADDRESS Edgewater Md

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22446

CERTIFICATE OF DEATH.

+ 174 E 22446

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Lewis Fishback

(a) RESIDENCE NO. 2709 36th St N.W. Washington D.C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Coleman Fishback

6 DATE OF BIRTH (month, day, and year) June 9/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	57	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Jacksonville, Ill.

PARENTS

10 NAME OF FATHER James Fishback

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Beatty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ill.

14 Informant Frederick C. Fishback (son)

(Address) Mayo Clinic Rochester Minn.

15 Date 5/20/1927 C. HAMPSON JONES, M. D. Registrar

Per RFH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-Threw himself into machinery at Phipps Clinic- Suicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Mental Depression

(duration) yrs. 5 mos. ....ds.

(Signed) J. B. Rich M. D.

(Coroner)

5/20/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC Date of Burial 5/20/27

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20 1927

Spec.—1-12-23—M&T—500 Bks.

E 22447 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22447

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital 14-29 ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ronald Robert Hagan

(a) RESIDENCE NO. 105 S. Calhoun St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Russell Hagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bernadine Thorpen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Russell Hagan (Address) 105 S. Calhoun St.

15 Filed 5/30, 1927 C. HAMPSON JONES, M. D. Registrar Per CHJ

20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 20, 1927, that I last saw him alive on May 20, 1927, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

5/30, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL May 31, 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1013 Pratt St

TION is very important See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 22448

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22448

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 19 E. 28th City Hosp. St., 71-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Fabus

(a) RESIDENCE NO. 719 Russell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Isaac Fabus

11 BIRTHPLACE OF FATHER (City or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Henrietta

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Mary Jones (Address) 1708 Eutaw St

15 Filed 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 5-18-27

17 I HEREBY CERTIFY, That I attended deceased from 7-12-, 19 26 to 5-18- 19 27

that I last saw h[illegible] alive on 5-18- 19 27

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH was as follows:

Epithelial Carcinoma

Tuberculosis

Tuberculosis Peritonitis

(Duration) [illegible] mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical Path

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: May 2 1927

20 UNDERTAKER: [illegible] H. Holland — ADDRESS: 1631 Druid

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22449

~~E 22449~~ 25

CERTIFICATE OF DEATH

JOHNS HOPKINS HOSPITAL

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 14-20 St. Ward)

2-FULL NAME Gwendolyn Campbell

(a) RESIDENCE NO. 1610 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0/ year	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Campbell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 19-1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 19, 1927, that I last saw h.r. alive on May 19-1927 19, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 38 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. S. Handley, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial May 21, 1927

20 UNDERTAKER Mrs. Geo. F. Holland ADDRESS 1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22450 ✓ 74-001 E 22450

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gattuso

(a) RESIDENCE NO. 402 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carmelia Gattuso

6 DATE OF BIRTH (month, day, and year) June 24/1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	36	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York City

PARENTS

10 NAME OF FATHER Carmel Gattuso

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Trapina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Carmelia Gattuso

(Address) 402 Aisquith St

Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Hemorrhage

Unilateral paralysis over

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) undetermined

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Fallen, M. D.

(Coroner)

5/20/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial May 21 1927

20 UNDERTAKER Woodall & Lippel ADDRESS 300 N. Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0 1927 NRH

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22451

E 22451

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 N. Paca St. St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Chenoweth

(a) RESIDENCE NO. 516 N. Paca St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Chenoweth

6 DATE OF BIRTH (month, day, and year): August 13 1854

7 AGE: Years 72. Months Days If less than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer): Own Work

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: William H. Iglehart

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Pattie Iglehart

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md.

14 Informant: Charles Neal

(Address): 516 N. Paca St

15 Filed May 20, 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. J. Hennessy M. D. (Coroner)

May 1927 Address 802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lindn Park Date of Burial: May 21 1927

20 UNDERTAKER: Mendell & Haspel ADDRESS: 3301 Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22452

E 22452

CERTIFICATE OF DEATH

151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lincoln & Lonely Lane St. 5-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Baeder

(a) RESIDENCE NO. Lincoln Lane Lonely Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Baeder

6 DATE OF BIRTH (month, day, and year): ~~Nov~~ Feb 13. 1841

7 AGE: Years 86. Months 3 Days 7 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Bernard Baeder

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Catherine Baeder

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany.

14 Informant: George Baedt

(Address): 1216 N. Hanover St.

21 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 1927 to May 20th 1927 that I last saw h... alive on May 19th 1927 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. ... mos ... da.

CONTRIBUTORY (Secondary): Senile Gangrene

(duration) ... yrs. 3 mos 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edward Behrens M. D.

5/20. 1927 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery. Date of Burial: May. 23 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Harford.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22453

E 22453

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 807 E. Lanvale St. St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward B. Morris.

(a) RESIDENCE NO. 807 E. Lanvale St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If ~~married~~, widowed, ~~divorced~~ HUSBAND of ~~XXXXXXXX~~ Lillie Morris.

6 DATE OF BIRTH (month, day, and year) November 11, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clergeman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Ida Wortman.

(Address) 807 E. Lanvale St.

15 Date 2 1 1927 C. HAMPSON JONES, M. D.

Per ADB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Geisecke M. D.
(Coroner)

5/21, 1927 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carbondale Pa Date of Burial May 21 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22454 — 125 — E 22454

CERTIFICATE OF DEATH.

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 5-4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Vieweg

(a) RESIDENCE NO. 432 N Caroline St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 Color or Race: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Katie Vieweg

6 DATE OF BIRTH (month, day, and year) Mar 8 / 61

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
66	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Furniture 886

(b) General nature of industry, business, or establishment in which employed (or employer): Mover

(c) Name of employer: Himself

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Frank Vieweg

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Germany

14 Informant: Katie Vieweg

(Address) 432 N. Carolina St

15 5 21 1927, 19 _____ C. CAMPBELL JOYCE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 - 1927, to May 20, 1927,

that I last saw him alive on May 20, 1927,

and that death occurred, on the date stated above, at 3 15 P.M.

The CAUSE OF DEATH* was as follows:

Rupture of Pancreas

Fat Necrosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? _____

(Signed) Abram J Hechtman, M. D.

5 20, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 5-23 1927

20 UNDERTAKER: Philip Henry Adams — ADDRESS 206

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Katie A Crane

E 22455 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22455

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2211 Roslyn ave ST. 15-61 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie A Crane

(a) RESIDENCE NO. 2211 Roslyn ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6/1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
68	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Mary's Co. Md.

PARENTS

10 NAME OF FATHER: Robert Crane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah B. Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Sarah J. Crane

(Address) 2211 Roslyn ave

15 21 1927 . 19 WR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 . 1927 . to May 18 . 1927.

that I last saw h[illegible] alive on May 16 . 1927.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 2

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage about 2 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter Tibbatt, M. D.

May 19, 1927 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Park — DATE OF BURIAL: May 21 1927

20 UNDERTAKER: John C. Hatchett & Son — ADDRESS: 1900 Eutaw Pl

C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22456 E 22456

CERTIFICATE OF DEATH

1-PLACE OF DEATH Woman's Hospital REGISTERED NO.

City of BALTIMORE: (No. John St. + Lafayette Ave St.) 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Cornelia Harcum

(a) RESIDENCE NO. Toronto, Canada Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3, 1881

7 AGE Years: 45 Months: 10 Days: 16 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Northumberland

(State or country) Virginia

PARENTS

10 NAME OF FATHER O. D. Harcum

11 BIRTHPLACE OF FATHER (City or town) Northumberland

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Cornelia Gaskins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Same as father

14 Informant Mrs. Samuel B. Harcum,

(Address) 4115 Ridgewood Rd. Wilmington.

15 Filed 1927, 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to May 19, 1927, that I last saw h[illegible] alive on May 19, 1927, and that death occurred, on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of breast, right.
(removed March 1925)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastatic carcinoma of left pleura (duration) — + yrs. — mos 71 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes! Date of { March 1925 / July 1926 }

Was there an autopsy? No! What test confirmed diagnosis? { March 1927 / May 1927 } Pathology

(Signed) Wm. W. Wilson, M. D.

, 19 (Address) Women's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemy. Date of Burial: May 23 1927

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS: 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

21 1927

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22457 E 22457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital Registered No.

City of BALTIMORE: (No. Lombard & Greene St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Chornyei

(a) Residence No. 415 W. Ostend St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Tena Chornyei

6-DATE OF BIRTH (month, day and year): Nov 15 1886

7-AGE: 39 yrs. 6 mos. 5 ds.

If LESS than 1 day, hrs. or. mdn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country): Hungaria

PARENTS.

10-NAME OF FATHER: [illegible]

11-BIRTHPLACE OF FATHER (city or town). (State or Country): Hungaria

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (city or town). (State or Country): Hungaria

14-

(Informant): [illegible]

(Address): 415 W. Ostend St.

15-

Filed 192 Registrar.

2 1 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 5-20-27

17- I HEREBY CERTIFY, That I attended deceased from 5-20, 1927 to 5-20 1927

that I last saw h[illegible] alive on 5-20 1927

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Placenta Praevia Centralis 1

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: May 23 1927

20-UNDERTAKER: E. Schuman Son — ADDRESS: 1039 Hanover

Instructions on back of certificates. See ... of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22458

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22458

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Madison Ave) (Ward) Aug 43-54

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Virginia Bastain

(a) RESIDENCE. No. 2308 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): March 1883

7 AGE — Years: 44 — Months: Mos — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philip Haywood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sydonia Haywood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mamie Stanley 1926 Appleton Ave City

15 Filed May 23 1927 C. HAMPSON JONES, M. D. Registrar

Per R.P.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to May 18 1927 that I last saw h[illegible] alive on May 18 1927 and that death occurred, on the date stated above, at 6:55 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis and Colitis - Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

5 (Signed) Bernard S. French, M. D.

, 1927 (Address) 707 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: May 21 1927

20 UNDERTAKER: Leonard Wade — ADDRESS: 308 Myrtle Ave

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22459

CERTIFICATE OF DEATH.

118-006

E 22459

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital. St. 25-75 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Englar.

(a) RESIDENCE NO. 107-4th Ave. Brooklyn Park St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced, (or) WIFE of: James B. Englar.

6 DATE OF BIRTH (month, day, and year): October 17, 1895.

7 AGE — Years: 81 — Months: 7 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): New York.

PARENTS

10 NAME OF FATHER: Ernst Sick Rehak.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria.

12 MAIDEN NAME OF MOTHER: Helen Barot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Do not know. Do not know.

14 Informant: James B. Englar. (husband)

(Address) 107-4th Ave Brooklyn Park.

15 Filed: C. HAMPSON JONES, M. D.

2 1 1927 By: RRB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(Signed) Otto Bernhardt M. D. (Coroner)

5/20, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. Date of Burial: May 21 1927

20 UNDERTAKER: W. M. Ponton ADDRESS 223 N. Smith

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-12-25—M&T—500 Bks.

E 22460

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3812 Hillsdale Rd (St.) 28-64 (Ward)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodor F. Lips

(a) RESIDENCE NO. 3812 Hillsdale Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Lips

6 DATE OF BIRTH (month, day, and year) Sept 16 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	82	8 4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulding Organ

(b) General nature of industry, business, or establishment in which employed (or employer) S.S. Co - 86

(c) Name of employer M. M. L. Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederic Lips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary L Lips

(Address) 3812 Hillsdale Rd

15 Filed MAY 21 1927 .19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 10 .1927 to May 19 .1927 that I last saw him alive on May 18 .1927 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

5/19 .1927 (Signed) Fritz J Kunzer, M. D.

(Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 21 1927

20 UNDERTAKER W M Rowlson

ADDRESS 2235 N Howard

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22461

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22461

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St Joseph's Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No.) 14-20 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Mullin

(a) RESIDENCE NO. 120 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	w	widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of James Mullin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER — Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jos. Kirby 9 South 1 St.

15 Filed 2 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to May 21, 1927, that I last saw her alive on May 21, 1927, and that death occurred, on the date stated above, at 7 40 m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

Arteriosclerosis

(Fractured Humerus (left) cured)

(duration) ... yrs. ... mos ds.

CONTRIBUTORY (Secondary) ~~about~~ 1½ yrs. Bronchopneumonia

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Labratory

(Signed) Clement R Woman, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL May 23 1927

20 UNDERTAKER H Womans & Son — ADDRESS 805 N. Calvert St

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22462

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22462

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 151 Wilkens St. 20th Ward)

2-FULL NAME Rudolph C. Junghans

(a) RESIDENCE NO. 151 Wilkens St. 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Nov 28 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town).....

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Germany

14 Informant Wm C. Junghans

(Address) 134 Collins Ave

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 18th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest

Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Illum. Gas
Dead when found

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

May 18th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial May 21st 1927

20 UNDERTAKER F. B. Wilfert ADDRESS 1850 W. Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

21 1927 C. HAMPSON JONES, M.D. Registrar

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22463 E 22463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3501 (Street) Cedardale Road (Ward) 45

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Eidman

(a) Residence No. 3501 (Street) Cedardale Road (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Geo Eidman

6-DATE OF BIRTH (month, day and year): May 24-1852

7-AGE: 74 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country):

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14- (Informant) Wm Eidman

(Address) 1022 W Lexington St

15-

Filed ... 192... C. HAMPSON JONES, M.D. Registrar

2 1 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 19 27 to May 19 27

that I last saw her alive on May 19 27

and that death occurred on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ileum

6

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G Schwarzbrock

5/21/27 19 (Address) 1124 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: May 23 19 27

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 22464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #616 Baker St. 15-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Callis

(a) RESIDENCE NO. 616 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Augustus B. Callis

6 DATE OF BIRTH (month, day, and year): Nov. 18. 1870?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
(55)	56	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Amherst Co. Va

PARENTS

10 NAME OF FATHER: Slave living

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mona (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: James A. B. Callis (Address) 616 Baker St

15 C. HAMPSON JONES, M. D. Registrar

Per

5 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 19, 1927, that I last saw her alive on May 18, 1927, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia — (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis (duration) yrs. 8 mos.? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm H Wright M. D.

5/19 1927 (Address) 1709 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: May 21 1927

20 UNDERTAKER: Jno M. Johnson — ADDRESS 1234 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.-7-17-26—A Co.—200 Bks.

E 22465

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22465

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1826 N. Castle St. 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Bayne

(a) RESIDENCE NO. 1826 N. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Bayne

6 DATE OF BIRTH (month, day, and year): June 23, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John J. Edwards

11 BIRTHPLACE OF FATHER (City or town) (State or country): Harford Co. Md

12 MAIDEN NAME OF MOTHER: Laura Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John S. Bayne

(Address): 1826 N. Castle St.

15 May 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 18, 1927.

That I last saw her alive on May 18, 1927,

and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Valvular H. Cond disease

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

May 19, 1927 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Cem	May 21 1927
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	1422 High St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22466 ✓ 131 E 22466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No.) St., (Ward) 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Sacco

(a) RESIDENCE NO. Macontown, Penna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mes. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Italian	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Agostino Salvatore

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Carolina Feirnice

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Reuels

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to May 20, 19 27, that I last saw him alive on May 20, 19 27, and that death occurred, on the date stated above, at 6 55 p m.

The CAUSE OF DEATH* was as follows:

Myocardial failure with acute pulmonary congestion

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of April 20, 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Everett Sumner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Welch W Va — Date of Burial 5/21/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

21 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22467
1-PLACE OF DEATH

51 E 22467
REGISTERED NO.

City of BALTIMORE: (No. 744. pennington. Ave St. 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrzej Nowakowski

(a) RESIDENCE NO. 744. pennington Ave. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	71	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) Storekeeper
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or conntry) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or conntry) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mieczyslaw Nowakowski
(Address) 744 S Pennington Ave

MAY 22 1927

E. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1927 to May 20, 1927
that I last saw h~~im~~ alive on May 20, 1927
and that death occurred, on the data stated above, at 6 P.M.
The CAUSE OF DEATH was as follows:
Diabetes; heart failure — acidosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis
(Signed) Nathan Welt Jost, M. D.
5/21 1927 (Address) 1 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross	5/23 1927

20 UNDERTAKER Wm Faelsowski ADDRESS 1618 Eastern

DO NOT WRITE IN THIS SPACE

Filed ____ 19 ____
by ____ Registrar

Name should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22468
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 22468
Registered No. C.....

City of BALTIMORE: (No. 1615 Harlem ave St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Goldmeyer

(Residence in Baltimore: No. 1615 Harlem ave St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Aug (Month) 19 (Day) 1840 (Year)

7-AGE. 86 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Goldmeyer

(Address) 1615 Harlem ave

15-

Filed ..... 192.... Registrar.

Per .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 20 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

May 22 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oheb Shalom Cem. DATE OF BURIAL. May 23 1927

20-UNDERTAKER. J. Ahrens Co. ADDRESS 3314 Reisterstown Rd

MAY 22 1927 C. HARPER VINCENT, M.D.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22469 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. ~~502 N Carey~~ Colored & adjacent ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME miss Yetta Fowler

(a) RESIDENCE No. 502 N Carrollst ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Harris Farher

6 DATE OF BIRTH (month, day, and year) Cathumen

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harris —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harris Farher

(Address) 502 N Carrollst

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/05/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/9/27, 1927, to 5/05/27, 1927 that I last saw her alive on 5/05/27, 1927 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage paralyzed & Uremic Convulsions

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) yrs. mos. 3 yrs

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. R. McConnell, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 5/7 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22470
1-PLACE OF DEATH

74-001

REGISTERED NO. 22470

City of BALTIMORE: (No. 3303 Weidon Ave. Ward 45-67)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza A. Calabough

(a) RESIDENCE NO. 3026 W. North Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced (or) WIFE of: William T Calabough

6 DATE OF BIRTH (month, day, and year): March 3- 1854

7 AGE: Years 73 Months 1 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Philadelphia
(State or country):

PARENTS

10 NAME OF FATHER: Timothy Flaherty

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Hynes

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Ireland

14 Informant: Charles E. Calabough
(Address) 3026 W. North Ave.

15 Filed MAY 22 1927 by C. HAMILTON JONES, M. D.
Registrar
Per RJ

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (died in bed)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): no history
(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Prosector)

(Address) 2102 Edmondson Ave.

May 21, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cathedral — Date of Burial: 5/23/27

20 UNDERTAKER: Wm Cook — ADDRESS: Govt Hosp.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22471

CERTIFICATE OF DEATH.

129 E 22471

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1228 Hanover St. St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet Brunette.

(a) RESIDENCE NO. 1228 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If ~~married, widowed, or divorced~~ (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.

(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) Do not know

(State or country)

14 Informant Albert Cummins.

(Address) 1228 Hanover St.

15 Filed ....., 19.... C. HAMPTON JONES, M. D.

MAY 22 1927 By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Chronic Valvulitis, Chronic Nephritis, Atterio Sclerosis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) H. A. Reinhardt M. D.
(Coroner)

5/20 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross A. A. Co	5/23 1927

20 UNDERTAKER	ADDRESS
J. F. McConley	130 E. Fort

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22472

46 E 22472

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 Race St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Burley

(a) RESIDENCE NO. 1121 Race St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Burley

6 DATE OF BIRTH (month, day, and year): Mar 17, 1885

7 AGE — Years: 42 Months: 2 Days: 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Caroline Co

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country):

12 MAIDEN NAME OF MOTHER: Louise Connor

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Joseph Burley

(Address): 1121 Race

15 Filed MAY 22 1927 Per R.H.

19 C. HAMPSON JONES M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/22, 1926 to 5/18, 1927.

that I last saw h ex alive on 5/18, 1927.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

of Uterus

(duration) — yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Drumheller M. D.

5/19 1927 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Furnace Branch Lan Date of Burial 5/22 1927

20 UNDERTAKER: Samuel A Hawley ADDRESS 57 E Biddle

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 22473

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22473

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 E. Third St. Ward) 27-56 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugo B. Otto

(Residence in Baltimore: No. 23 Summit Ave St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. 16 (Month) (Day) 1867 (Year)

7-AGE. 59 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). Gunthers Brewery

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Adam Otto

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Clara Seidel

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Otto

(Address) 23 Summit Ave

15- Filed MAY 22 1927 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20 (Month) (Day) 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 6 Days yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Nephritis

(Duration) Years yrs. mos. ds.

(Signed) C. C. Weed M. D. (Coroner)

5-22-27 192.. (Address) 17 N. Gray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Schwartz Ave DATE OF BURIAL. May 23 1927

20-UNDERTAKER, Mr & Mrs. J. W. Templeton & Son ADDRESS 801 W. Fayette St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22474

CERTIFICATE OF DEATH.

129 E 22474

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Sauer

(a) RESIDENCE NO. 1002 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew K. Sauers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Joseph Sauers (Address) 1414 Edmonson ave

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

X 22 1927

P61

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 20, 1927.

that I last saw him alive on May 20, 1927.

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis c Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 23 1927

20 UNDERTAKER Chas. G. Black

ADDRESS 1424 Northern

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22475

CERTIFICATE OF DEATH

E 22475

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Orchard 6th (St., 25-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A. Headley Sr.

(a) RESIDENCE NO. Orchard & 6th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 15 1925

7 AGE — Years: 2 — Months: — Days: 6 — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) Hillcrest

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George A. Headley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E McLellan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Conn.

14 Informant George A. Headley

(Address) Hillcrest

15 Filed MAY 22 1927 19 C. HAMPSON JONES, M. D. 16 Registrar

Per LR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/27 19

17 I HEREBY CERTIFY, That I attended deceased from May 20— 1927 to May 21— 1927

that I last saw him alive on 5/20— 1927

and that death occurred, on the date stated above, at 5300 A m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) — yrs. — mos 21 ds.

18 Where was disease contracted Home

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History & Cure

(Signed) W. Hillcrest M. D.

, t9 (Address) 1340 Orchard

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: May 22 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 E 22476

E 22476

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 W. Fayette ST. 11-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Dingley Jr.;

(a) RESIDENCE NO. 650 W. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	10	27	26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Henry Dingley

11 BIRTHPLACE OF FATHER (city or town) Chester (State or country) Pa.

12 MAIDEN NAME OF MOTHER Edna Gallagher

13 BIRTHPLACE OF MOTHER (city or town) Anglesea (State or country) N. J.

14 Informant William Henry Dingley (Address) 650 W. Fayette St.

15 Filed JAN 22 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21- 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-9- 1927, to 5-21- 1927, that I last saw him alive on 5-21- 1927, and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

5-21-1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery

DATE OF BURIAL 5-22 1927

20 UNDERTAKER H. C. Brauning & Son

ADDRESS 317 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-08

E 22477

REGISTERED NO. 23-33

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1228 Marshall St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvador Maisch

(a) RESIDENCE NO. 1228 Marshall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 18, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John H. Maisch

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Miguet

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant John H. Maisch

(Address) 1228 Marshall St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per KM.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1927. to May 22, 1927

that I last saw h[illegible] alive on May 22 1927

and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Premature Birth 7 months

(duration) 7 mos yrs. mos da.

CONTRIBUTORY Exhaustion

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Stone, M. D.

May 23 19 27 (Address) 107 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial May 23 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E22478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001 ~~22478~~ E22478

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 823 W. Lombard St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Gahan

(a) RESIDENCE NO. 823 W. Lombard St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1- 1864

7 AGE — Years: 63 Months: Days: 19

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Gahan

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Teresa Fitzsimmons

(Address) 1820 St. Paul St.

15 Filed MAY 22 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1927. to May 20. 1927.

that I last saw him alive on May 20. 1927.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis,

(duration) 0 yrs. 0 mos. 1 da.

CONTRIBUTORY (Secondary) Gastric Ulcer (Ruptured)

(duration) 0 yrs. 0 mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam.

(Signed) John Gorton, M. D.

19 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Bom

Date of Burial: 5/23/1927

20 UNDERTAKER: J. J. Moran

ADDRESS 300 E. Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 22479

CERTIFICATE OF DEATH.

E 22479

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2014 Kennedy Ave St., 9-16 Ward)

2-FULL NAME Mary Shadduck

(a) RESIDENCE NO. 2014 Kennedy Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Christian Shadduck

6 DATE OF BIRTH (month, day, and year) March 12/1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Penna

PARENTS

10 NAME OF FATHER John Merrill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Zorner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Ada Saunders

(Address) 2014 Kennedy Ave

Filed MAY 23 1927 C. HAMPSON JONES M. D. Registrar

Per RH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Bacon M. D.

(Coroner)

5/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clearfield, Pa. Date of Burial 5/25/27

20 UNDERTAKER George J. Ruth ADDRESS 1535 Hanover

Do not state as cause of death MERELY A SYMPTOM OF DISEASE, but the DISEASE CAUSING IT. Also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22480 ~~E 22480~~ ~~E 22480~~ E 22480

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4406 Ethland Ave St. 28-64 Ward)

2-FULL NAME Josephine Thines

(a) RESIDENCE NO. Sharpsburg, Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Jacob H. Thines

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 62 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Virginia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant Hubert C. Eachusday

(Address) Keedysville, Md

15 Filed _____, 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

May 27 1927 (Address) 1802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Keedysville, Md — Date of Burial: May 29 1927

20 UNDERTAKER: Wm J. Dickson & Sons — ADDRESS: Ft Pat

MAY 23 1927

C. H. Haverkamp, M. D.

Registrar

Use pencil or carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 22481

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22481

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Gold ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ford J. Rollins

(a) RESIDENCE NO. 607 Gold ST. ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zenetta Rollins

6 DATE OF BIRTH (month, day, and year) Aug 5th 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Wood & Ice Dlr

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Coal Wood & Ice

(c) Name of employer Self

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER Ford J. Rollins

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Dixon

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md

14 Informant Zenetta Rollins (Address) 607 Gold St

MAY 23 1927

C. HAMPSON JONES, M. D. Registrar

Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1927, to May 20th, 1927, that I last saw h alive on May 19th, 1927, and that death occurred, on the date stated above, at 8-15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

a Bronchitis (duration) — yrs 2 mos — ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Examination

(Signed) Edward E. Mackenzie M. D.

May 22, 1927 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 27, 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1037 Hand Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22482 — REGISTERED NO. — E 22482

33

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Bell

(a) RESIDENCE NO. 1031 Druid Hill ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20 1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	13	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER John W. Bell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto City

12 MAIDEN NAME OF MOTHER Mamie Mathews

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lillian E. Bell

(Address) 1031 Druid Hill ave

15 Filed MAY 23 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to May 21, 1927

that I last saw h[illegible] alive on May 21, 1927

and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Glandular
Generalized Tuberculous Ulcers and
Tuberculized Peritonitis

(duration) 2 mos. 1 da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of May 21, 1927

Was there an autopsy? No

What test confirmed diagnosis? Glandular

(Signed) W. Bruce Reed M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cedar Lawn — May 23 1927

20 UNDERTAKER — ADDRESS

David Carson — Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22483

CERTIFICATE OF DEATH.

E 22483

REGISTERED NO. 314

1-PLACE OF DEATH Pronced dead at

City of BALTIMORE: (No. Balt City Hospital 425 St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther Green

(a) RESIDENCE NO. 641 Vine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Green

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of Industry, business, or establishment in which employed (or employer) Barbecue

(c) Name of employer Glass

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Lillie Green

(Address) 641 Vine

Filed MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

RAK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

5/24, 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 23 1927

20 UNDERTAKER Daniel Easton ADDRESS 824 E Eager

If death occurred in a hospital or institution, the information required should be furnished by an executive officer thereof. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 22484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 22484

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 633 Sara Ann ST., 4-25 WARD)

2-FULL NAME Henry Sherman Carter

(a) RESIDENCE NO. 633 Sara Ann ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lucy Carter

6 DATE OF BIRTH (month, day, and year) Apr. 11 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Balto. Carolina S.S. Co

9 BIRTHPLACE (city or town) (State or country) Essex Co Va.

PARENTS

10 NAME OF FATHER Richard Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Lucy Carter

(Address) 633 Sara Ann St

15 Filed MAY 23 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from May 18 1927 to May 20 1927.

that I last saw him alive on May 20 1927.

and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) 1 yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) R B Kenyon M. D.

May 23, 1927 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

W Laurel Cem May 23/27

20 UNDERTAKER — ADDRESS

Dennis Carroll Balt

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22485

CERTIFICATE OF DEATH.

90 E 22485

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St. [illegible] Ward) 19-27

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Mitchell

(a) RESIDENCE NO. 1523 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1872 - given 1885 - Brown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
Brown given	42 - 55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland ?

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Hannah ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant MORE CITY HOSPITALS

(Address) Records

15 Filed 19 C. HAMPSON JONES, M. D.

Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to May 20, 1927, that I last saw h[illegible] alive on May 20, 1927, and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Insufficiency

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death[illegible]

Did an operation precede death[illegible] no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general laboratory

(Signed) R. Hobart Smith, M. D.

May 20 1927 (Address) MORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 23-1927

20 UNDERTAKER Edward Easton ADDRESS Balt

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22486

CERTIFICATE OF DEATH

E 22486

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) 27-56

2-FULL NAME Edgar Brilhart

(a) RESIDENCE NO. 503 Belvedere Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 - 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Ice business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester, Md.

PARENTS

10 NAME OF FATHER Earl Brilhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Fuhrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Fuhrman

(Address) 503 Belvedere Ave

15 Filed ..... 192 .....

C. HAMPSON JONES

JAN 23 1927

By RRK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/16/27, 19 , to 5/22/27, 19 ,

that I last saw him alive on 5/22/27, 19 ,

and that death occurred, on the date stated above, at 4 15/6 m.

The CAUSE OF DEATH* was as follows:

acute appendicitis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no 5/16/27

Did an operation precede death? yes Date of 5/22/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. Wallace Walker, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester	May 25 1927
20 UNDERTAKER	ADDRESS
Jacob Wink & Son	Manchester Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22487 × 41 E 22487

E 22487 REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33rd and Calvert Sts. Ward) 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Levi Justice

(a) RESIDENCE NO. Brooklyn Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Levi Justice

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than I day ..... hrs. or ..... min..
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER John Justice

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Musgrove

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Mr. Levi C. Justice,

(Address) Emmsm's Dairy

Filed MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

Per R K R

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1927, to May 23, 1927,

that I last saw h.im alive on May 22, 1927,

and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Septic infection of hand and arm, right

(duration) about yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at St. Vincents

Did an operation precede death? Yes Date of 5/5/27 & 5/19/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond J Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial May 25 19 27

20 UNDERTAKER H. S. Marshall ADDRESS 3539 Fall Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22488

CERTIFICATE OF DEATH.

3 | **E 22488**

1-PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 715 St. Peter St. Ward) 21-24

2-FULL NAME John. Burgman Sr.

(a) RESIDENCE No. 715 St. Peter St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Fannie M. Bell.

6 DATE OF BIRTH (month, day, and year) Feby 19th 1860

7 AGE	Years.	Months.	Days	IF LESS than 1 day.....hrs. or.....min.
	67	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Clerk. retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Frank. Burgman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Cornelia Wieland.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs Fannie M Burgman

(Address) 24 St Peter St

Filed MAY 23 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 20 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 19 27, to May 20, 19 27, that I last saw h... alive on May 19, 19 27, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

5/24, 19 27 (Address) 517 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 5/27 1927

20 UNDERTAKER John J Cowan & Son ADDRESS 901 Holliday St.

Reg.

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-9-25 A Co. 200 Bks.

E 22489

20307

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-004

E 22489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. _____

City of BALTIMORE: (No. _____ St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Ackerman

(a) RESIDENCE NO. 1727 E Lombard St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~: Jennie Ackerman

6 DATE OF BIRTH (month, day, and year): Feb 17 1877

7 AGE: Years 50 | Months 3 | Days 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Caper (barrel maker)

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) Roumania

PARENTS

10 NAME OF FATHER Soloman Ackerman

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Russia

12 MAIDEN NAME OF MOTHER Sadie ?

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Russia

14 Informant Records

(Address) JOHN'S HOPKINS HOSPITAL

15 Filed _____, 19 _____ RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 22, 1927, that I last saw him alive on May 22, 1927, and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute lobar

Septicemia, pneumococcus, type IV

(duration) _____ yrs. _____ mos. 11 ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? New York City (?)

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) Clyde Fitch Johnston, M. D.

5/27/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. Date of Burial 5/23 19 27

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22490

CERTIFICATE OF DEATH.

90 E 22490

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Stevenson ave ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Kuff

(a) RESIDENCE NO. 926 Stevenson ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Kuff

6 DATE OF BIRTH (month, day, and year) March 1-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Kuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Kuff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Eastern Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to May 22, 1927, that I last saw h[illegible] alive on May 22, 1927, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab

(Signed) Isidor S. Levy, M. D.

May 1927 (Address) 2036 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dehlem Southern Ave — DATE OF BURIAL 5/23 1927

20 UNDERTAKER Jack Lewis 1439 Eastern Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 2-001

E 22491

CERTIFICATE OF DEATH

E 22491

Mount Park REGISTERED NO. 25-72

1-PLACE OF DEATH

City of BALTIMORE: (No. 1214 Seventh St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kayler

(a) RESIDENCE NO. 1214 Seventh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	white	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Bertie Kayler

6 DATE OF BIRTH (month, day, and year) April 14 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	49	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ohio

PARENTS

10 NAME OF FATHER John Kayler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Bertie Kayler

(Address) 1214 Seventh St Baltimore

15 Filed MAY 23 1927 Per R. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to May 20, 1927, that I last saw h. m. alive on May 20, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral of Lues

3 mos. ds.

(duration) yrs.

CONTRIBUTORY (Secondary) Myocarditis 1

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C M Olcott, M. D.

May 21 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial May 23 1927

20 UNDERTAKER Jos Joesolens Son ADDRESS 2178 Penn

N. B.—WHITE PEARL, WITH CAPADAIR INK—THIS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22492

CERTIFICATE OF DEATH

E 22492

74-001

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 398 S. Arlington ave. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarethia Sehlsicker

(a) RESIDENCE NO. 398 S. Arlington ave Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John N. Sehlsicker

6 DATE OF BIRTH (month, day, and year) May 16 1840

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	86	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER John Reitz

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mr. Nicholas Sehlsicker
(Address) 398 S. Arlington Ave

15 Filed ..... 19 ..... Registrar

MAY 23 1927 R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1927, to May 21, 1927, that I last saw h.. alive on May 20, 1927, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. 1 mos. 9 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) John Eberle, M. D.

May 23 1927 (Address) 708 N. Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — Date of Burial May 24 1927

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 217 S. Bro...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22493

X V 101-002

1-PLACE OF DEATH 1213 Light Street

City of BALTIMORE: (No. So. Balto Gen. Hospital 04-33 Ward)

REGISTERED NO. E 22493

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Catherine Scheel

(a) RESIDENCE NO. Linthicum Heights Ward Anne Arundel Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 21 — 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: State Normal School

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: William H. Scheel

11 BIRTHPLACE OF FATHER (city or town): Buffalo N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER: Susan Rainig

13 BIRTHPLACE OF MOTHER (city or town): Buffalo N.Y.

(State or country)

14 Informant: Helen C. Scheel

(Address) Linthicum Heights Md

MAY 23 1927

Filed HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

22 May 1927

17 I HEREBY CERTIFY, That I attended deceased from 25 Apr, 1927, to 22 May, 1927, that I last saw her alive on 22 May, 1927, and that death occurred, on the date stated above, at 705 p m.

The CAUSE OF DEATH* was as follows: Diffuse Pneumonia - Generalized Both Lungs - Atypical

(duration) 3 weeks — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) Lowell Usaner M. D.

22 May 1927 (Address) Linthicum Heights Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: May 24 1927

20 UNDERTAKER: John C. Mitchell Sons ADDRESS: Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22494

E 22494

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1122 Homewood Ave St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Dinan

(a) RESIDENCE NO. 1122 Homewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Nora Hanrahan Dinan

6 DATE OF BIRTH (month, day, and year): Jany 7. 1866

7 AGE: Years 61 Months 4 Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): clerk

(c) Name of employer

9 BIRTHPLACE (city or town): Fred. Co.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Maurice Dinan

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hannah Riordan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Nora H. Dinan

(Address) 1122 Homewood ave

15 Filed ..... 19 ..... Registrar .....

MAY 23 1927 C. HAMPSON YOUNG M.D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to May 20, 1927.

that I last saw him alive on May 20, 1927

and that death occurred, on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): General arterio sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 1122 Homewood ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

5 20 1927 (Address) 708 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial: May 24 1927

20 UNDERTAKER: John O. Mitchell & Sons ADDRESS: 1911 E. Eutaw Place

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22495

Plat of Cemetery

CERTIFICATE OF DEATH.

187-001

E 22495

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Armour Packing Co. St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earle. T. Murray

(a) RESIDENCE NO. 2420 E Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 31 1911

7 AGE: Years 16 Months 2 Days 19 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Armour Packing Co

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Earl W Murray

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Lazzette Martin

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Earl W Murray

(Address): 1420 E Lanvale St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull (Struck by Car Accident)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Claude Ryland M. D.

(Coroner)

2347 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Co. Date of Burial: May 23. 27

20 UNDERTAKER: Leo F Cook ADDRESS: 1723 Patterson Park Ave

(1) Items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 25 1927 HAMPSON MOORE M. D.

...—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22496 CERTIFICATE OF DEATH. 129 **E 22496**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hospital (St.) 22-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Lee Matthews

(a) RESIDENCE NO. 2318 N. Charles st ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ? mos. ! ds. How long in U. S., if of foreign birth? 60 yrs. 6 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William V. Matthews

6 DATE OF BIRTH (month, day, and year): Nov 3, 1866

7 AGE — Years: 60 — Months: 6 — Days: 19 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward V. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records

15 [illegible] C. HAMPTON JONES, M. D. Registrar

MAY 23 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5 - 22 - 1927

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to May 22, 1927, that I last saw her alive on May 22, 1927, and that death occurred, on the date stated above, at 5.05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac Failure

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ebenezer Somerset Co. Md. — DATE OF BURIAL: May 23 1927

UNDERTAKER: Edward Mann Co. — ADDRESS: Fort W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22497

REGISTERED NO. 90 E 22497

1-PLACE OF DEATH

City of BALTIMORE: (No.) Hopkins Apts. St. 12-50 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Winkelmann

(a) RESIDENCE NO. Hopkins Apts. St. 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs 11 mos. 1 ds. How long in U. S. if of foreign birth? 84 yrs 11 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Winkelmann

6 DATE OF BIRTH (month, day, and year) June-21-1842

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	84	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER G. Henry P. Winkelmann

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Bregel

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Germany

14 Informant Harry C. Winkelmann, (son)

(Address) Hopkins Apts., City.

15 Filed MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1927, to May 22nd, 1927, that I last saw h[illegible] alive on May 21st, 1927, and that death occurred, on the data stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema due to fatty Cardiac Confusion

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) — yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jefferson Buck M. D.

5/27 1927 (Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial May-24-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN OF DEATH in plain terms, so that it may be properly classified. Exact and very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Nowicki

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22498

CERTIFICATE OF DEATH

100-001

E 22498

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 925 S Clinton St St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacqueline Nowicki

(a) RESIDENCE NO. 925 S Clinton St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 23 1925

7 AGE: Years 1 Months 4 Days 28

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Nowicki

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Stanislawa Lechert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Joseph Nowicki

(Address) 925 S Clinton St

15 Filed MAY 23 1927

H. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 21, 1927, that I last saw h.CR alive on May 21, 1927 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C. S. D.

(Signed) H. J. Szeliski, M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary cem

Date of Burial: May 24 1927

20 UNDERTAKER: John McWeber

ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12 9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22499

CERTIFICATE OF DEATH.

59-002

E 22499

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3300 Mueller St St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon P Dumbar

(a) RESIDENCE NO. 3300 Mueller St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9 1927

7 AGE — Years | Months | Days: 13 | IF LESS than 1 day.....hrs. or.....min.: 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Indnstry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Dumbar

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: Theresa Cole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant: William Dumbar

(Address): 3300 Mueller St

15 Filed MAY 23 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/1 19 27, to 5/22 19 27, that I last saw h.. alive on 5/20 19 27, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Connell M. D.

5/22 1927 (Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem Date of Burial May 23 1927

20 UNDERTAKER: John C. Miller ADDRESS 2435 E Oliver

NOTE.—WHILE PHYSICIANS ARE CHARGED NO FEES AS PENALTY FOR NEGLECT TO REPORT, they can render a service to the community by seeing that information on this certificate is complete and correct. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Solenger

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22500

E 22500

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St. 7-9 Ward)

2-FULL NAME Florida Lessiter

(a) RESIDENCE NO. Manchester St. Md Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1-6-1922

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
4 y 5 3/7 yrs	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Gene Lessiter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Snyder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL C. HAMPTON JONES, M. D.

15 Filed MAY 23 1927 19 Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to May 22, 1927, that I last saw h[illegible] alive on May 22, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, Pneumococcus

(duration) ___ yrs. ___ mos. 3 ds.

CONTRIBUTORY (Secondary) Otitis media + Sinusitis

(duration) ___ yrs. 1½ mos. ___ ds.

18 Where was disease contracted if not at place of death? Manchester, Md.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md. Date of Burial May 25 1927

20 UNDERTAKER Jacob Winks Sons ADDRESS Manchester Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22501

90

REGISTERED NO. E 22501

1-PLACE OF DEATH

City of BALTIMORE: (No. 3455 Hickory Ave St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Knight

(a) RESIDENCE NO. 3455 Hickory Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (Late) James A. Knight.

6 DATE OF BIRTH (month, day, and year): May 30, 1844

7 AGE — Years: 82 — Months: 11 — Days: 20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: James Purdahm

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Knight.

(Address) 3455 Hickory Ave.

Filed MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 20, 1927, that I last saw h[illegible] alive on May 20, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Uremia

(duration) 1 yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Cardio Nephritis

Arteriosclerosis (duration) ? yrs. mos. da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edmund J. Kelly, M. D.

5/23/1927 (Address) 4 Lowndes Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — Date of Burial: May 23, 1927

20 UNDERTAKER: Thenow Olson — ADDRESS: 3615 Rhode Island Ave

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22502

CERTIFICATE OF DEATH.

164

E 22502

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 2 Ward) 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Schneider

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Schneider

6 DATE OF BIRTH (month, day, and year) Aug 1st 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Francis Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Brady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Little Sisters of the Poor

(Address) Preston & Valley

15 Filed MAY 23 1927 R. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 22nd

17 I HEREBY CERTIFY, That I attended deceased from Novr 22nd, 19.....to 19.....,

that I last saw h.s alive on May 17, 1927,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 23, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Smallwood Cemetery Carroll Co, Md. Date of Burial May 25 1927

20 UNDERTAKER Nelson E. Stiles ADDRESS 231 Md. Ave Westport

MAY 23 1927

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22503

CERTIFICATE OF DEATH.

E 22503

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St., 15-21 Ward)

2-FULL NAME Joseph H. Collins

(a) RESIDENCE NO. 1742 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Collins.

6 DATE OF BIRTH (month, day, and year) 1866 Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Frances —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Vit. Records

15 Filed MAY 23 1927 Per R. H. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 20, 1927, that I last saw him alive on May 19, 1927, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general clinical

(Signed) R Hooper Lovett, M. D.

May 7 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — Date of Burial May 23 1927

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Reisterstown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22504

CERTIFICATE OF DEATH.

E 22504

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1011 N. Caroline ST., 7-13 WARD)

2-FULL NAME Harry Bailey Neidhammer

(a) RESIDENCE NO. 1011 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clara Bailey Neidhammer

6 DATE OF BIRTH (month, day, and year) June 19 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	56	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Theatrical

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Neidhammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Jennie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Clara Bailey Neidhammer

(Address) 1011 N. Caroline St. M. D.

15 Filed MAY 23 1927, 19 C. HAMILTON JONES, M. D. Registrar

Per H.J.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927 to May 21 1927 that I last saw him alive on May 21 1927 and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Uraemia

(Signed) C. C. Hoffman, M. D.

5/24, 19 27 (Address) 1102 No. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 24 1927

20 UNDERTAKER Henry Heuck & Sons — ADDRESS 1301 E. Fayette

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22505

CERTIFICATE OF DEATH.

162

E 22505

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Andrews

(a) RESIDENCE NO. 768 S Decker Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1927

7 AGE Years Months Days IF LESS than 1 day 20 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Anthony Andrews

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Salina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records

(Address)

MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

By R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1927, to 5-22, 1927, that I last saw h-er alive on 5-22 1927 and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the newborn.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Horner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 5/23 1927

20 UNDERTAKER D. J. Murphy ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 22506 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22506

CERTIFICATE OF DEATH. 124

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 96-42 St.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Greif

(a) RESIDENCE NO. 2807 Glenwood Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Greif

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Thomas H. Greif (Son)
(Address) 2807 Glenwood Ave

15 Filed MAY 23 1927 C. HAMPSON CURRAN Per R M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927 to May 21, 1927 that I last saw h[illegible] alive on May 21, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis & Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 24 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St

MAY 23 1927

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22507

CERTIFICATE OF DEATH.

49

E 22507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore general Hospital

CITY OF BALTIMORE: (No. Region and Dukeland ST.) 6-10 (WARD)

2-FULL NAME Annie Leithauser

(a) RESIDENCE NO. 116 N. Kenwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 31. 1866

7 AGE: Years 60 | Months 6 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Leithauser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: A. M. Groh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John H. Leithauser

(Address) 116 N. Kenwood ave

15 Filed May 23, 1927 C. HAMPSON JONES, Per R M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/10 1927, to 5/22 1927, that I last saw her alive on 5/22 1927 and that death occurred, on the date stated above, at 7 05 P. m.

The CAUSE OF DEATH* was as follows:

Cancroma of lung

(duration) yrs. 5 mos dys.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & H.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: May 25 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22508 — REGISTERED E 22508

90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. 46 E. Heath St. St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Wheeler.

(a) RESIDENCE NO. 46 E. Heath St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXXXXXXX XXXXXXXXXX Claire S. Wheeler.

6 DATE OF BIRTH (month, day, and year) August 19, 1865.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William A. Wheeler.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Letitia McLaughlin.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Claire S. Wheeler. (wife)

(Address) 46 E. Heath St.

MAY 23 1927 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 May 21, 7.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency, Myocardial Fibrosis, Sclerosis of Coronaries. Advanced Arteriosclerosis. Oedema and congestion of the Lungs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

5/28 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem Date of Burial 5/23 1927

20 UNDERTAKER J. F. McCully ADDRESS 1308 E. Fort

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22509

CERTIFICATE OF DEATH.

182

E 22509

1-PLACE OF DEATH Cabin Branch Bridge,

City of BALTIMORE: (No. Curtis Bay. St. 25-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Baworski.

(a) RESIDENCE NO. 22 Church St. Curtis Bay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6 DATE OF BIRTH (month, day, and year): May 20, 1919.

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
8	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Peter Baworski,

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Poland.

12 MAIDEN NAME OF MOTHER: Mary Cowich.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Poland.

14 Informant: Peter Baworski. (father)

(Address) 22 Church St. Curtis Bay.

15 Filed ..... 19 ..... A. M. P. M. C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 192 7.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a row boat.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Bernhardt M. D.

(Coroner)

5/28 19 27 (Address) 7017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — Date of Burial: May 24 1927

20 UNDERTAKER: Geo. L. Crockson — ADDRESS: 1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 22510

E 22510

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 16-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wensing

(a) RESIDENCE NO. 2924 Boughton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S. if of foreign birth 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wensing

6 DATE OF BIRTH (month, day, and year) July 9 – 1840

7 AGE Years 86 Months 10 Days 18 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country) Baden

PARENTS

10 NAME OF FATHER Daniel Lachmann

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wahl

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Leonard B. Williams

(Address) 2924 Boughton St.

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 5-21-

17 I HEREBY CERTIFY, That I attended deceased from 10-30 1927 to 5-21- 1927

that I last saw her alive on 5-21 1927

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH was as follows:

Generalized Arteriosclerosis

Chronic Myocarditis

Varicose Ulcer Right Leg

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Eugene M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery Date of Burial May 24 1927

20 UNDERTAKER Wilbur W. Shivers ADDRESS 1018 Edmondson Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22511

CERTIFICATE OF DEATH.

E 22511

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 37-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 14-20 ST., WARD)

2-FULL NAME Bessie Randolph

(a) RESIDENCE NO. 158 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (or) WIFE of Charles Randolph

6 DATE OF BIRTH (month, day, and year) December

7 AGE: Years 57 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Gilbert Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant Charles Randolph

(Address) 1050 Penna. Ave

15 Filed MAY 23 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 18, 1927.

that I last saw h alive on May 18, 1927.

and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Lupus Erythematosus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

UNDERTAKER B. O. John M. Johnson

DATE OF BURIAL May 23 19 27

ADDRESS 1234 Etting St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Charles E Fogle.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22512

CERTIFICATE OF DEATH.

197 E 22512

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 4-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C E Fogle

(a) RESIDENCE NO. 744 W Balto St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-10-1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Emil Fogle.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Celia Horton.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Emil Fogle,

(Address) R F D New Windsor, Md.

Rec'd MAY 23 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide

Gun Shot of Abdomen

Onset Apr. 5/27

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Peritonitis & Sepsis

(duration) 7 yrs. 2 mos. 11 ds.

May (Signed) Geo Climie Pfeiffer M. D.

(Coroner)

23 (Address) 143 W Fayette

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co., Md. Taylorsville Cemetery. Date of Burial 5/24 1927.

20 UNDERTAKER C. M. Waltz. ADDRESS Winfield Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22513 ✓ 188-007 **E 22513**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute to St. Joseph Hospital St. 9-17 Ward)

2-FULL NAME Carl Burch Ireland

(a) RESIDENCE NO. 110 E. Bragg St., Greensboro, N.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helene Ireland

6 DATE OF BIRTH (month, day, and year) July 23/1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hotel Mgr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Burlington, N.C.

PARENTS

10 NAME OF FATHER Wesley Ireland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER Mollie Burch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Helene Flear Ireland
(Address) 110 E. Bragg St
Greensboro, N.C.

15 Filed MAY 23 1927 16 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-intra-cranial Hem. Motorcycle accident on Belair Road nr Hamilton Ave

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Wilson M. D.
(Coroner)
5/23/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N. Carolina Date of Burial May 23 1927

20 UNDERTAKER Richard F. Curley ADDRESS 2016 North Ave

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22514

CERTIFICATE OF DEATH

22514

REGISTERED NO. 31 E 22514

1-PLACE OF DEATH

City of BALTIMORE: (No. 2210 E. Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R. Sharkey

(a) RESIDENCE NO. 2210 E. Chase St. 8 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 7 mos. 20 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	22	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Sun

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John J. Sharkey

11 BIRTHPLACE OF FATHER (City or town) Ireland.

(State or country)

12 MAIDEN NAME OF MOTHER Maria Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Maria Sharkey.

(Address) 2210 E. Chase St.

15 Filed MAY 23 1927 16 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to May 22, 1927.

that I last saw him alive on May 20, 1927.

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH was as follows: Phthisis Pulmonalis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray. Laboratory test

(Signed) J. Albert Gring M. D.

May 25 1927 (Address) 1613 N. Wash. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cathedral Cemetery	May 24 1927
20 UNDERTAKER Lilly-Zeiler.	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22515

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 Josephine St., 4-25 Ward) 113

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Moon

(a) RESIDENCE NO. 640 Josephine St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			2 1 0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Arthur Moore

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Miss.

12 MAIDEN NAME OF MOTHER Christine Bass

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Va.

14 Informant.....

(Address)

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

1 mo. Baby (duration) ___ yrs. ___ mos. 3 mds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ___ yrs. ___ mos. ___ ds.

May 21 1927 (Signed) H C Wade M. D.

(Coroner)

(Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

23 1927 1384

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22516 E 22516

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 626 W North ave St., 13-70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Keely Byrne

(a) Residence No. 626 W North ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Byrne

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 84 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Nova Scotia

PARENTS.

10-NAME OF FATHER. Richard Wm. Keily

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Julia Kelly

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Ireland

14- (Informant) Chas. P. Byrne

(Address) 626 W. North Ave.

15- Filed MAY 23 1927 C. HAMPSON JONES, M. D. Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22 1927

17- I HEREBY CERTIFY, That I attended deceased from Jany 8, 1927 to May 22 1927

that I last saw h.. alive on May 22 1927

and that death occurred, on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. P. Claude M. D.

May 22 1927 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	5/25 19 27

20-UNDERTAKER.	ADDRESS
Henry U. Myers & Son	805 N Calvert

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22517

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-28 St., WARD)

2-FULL NAME George P. Melbert

(a) RESIDENCE No. 1807 Hillen Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ethel Melbert

6 DATE OF BIRTH (month, day, and year) Dec 12 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	31	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Art Rep. Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER George Melbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Ethel Melbert

(Address) 1807 Hillen Ave

15 C. HAMPSON JONES, M. D. Registrar

JUN 23 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 21, 1927, that I last saw him alive on May 21, 1927, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses of liver

History (duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of May 10, 27

Laparotomy + Drainage

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operative

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL May 25 1927

20 UNDERTAKER Geiger & Farley Sutton

ADDRESS Fayette & Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See Instructions on back of certificates. PHYSICIANS should write AGE should be stated EXACTLY.

Spec.—7-17-26—A Co.—200 Bks.

Carter

E 22518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22518

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (Col.) 21-31 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Carter

(a) RESIDENCE NO. 700 Warner st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days
	27		

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Berry Carter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ella Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed 2 3 1927 C. HAMPSON JONES, M. D. Registrar

By RCH

1382

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 29, 19 27, to May 19, 19 27, that I last saw him alive on May 19, 19 27, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W E Gattens, M. D.

19 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Superintendent Health. MAY 2 1927

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22519

100-001

E 22519

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 W 21 st St. 12-20 Ward)

2-FULL NAME Stewart McCarty Jr.

(a) RESIDENCE NO. 317 W 21 st St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 4.5.27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	17/18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Stewart S. McCarty

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER Signi Larsen

13 BIRTHPLACE OF MOTHER (city or town): Sweden

(State or country)

14 Informant Stewart S. McCarty

(Address) 317 W 21st St.

23 1927 C. HAMPSON JONES, M. D.

_____, 19____ Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5.23 1927

17 I HEREBY CERTIFY, That I attended deceased from 5.18, 1927, to 5.23, 1927, that I last saw him alive on 5.23, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ___ yrs. ___ mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. J. Sinclair, M. D.

, 19 (Address) 1026 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial 5/23 1927

20 UNDERTAKER: J. F. McCully — ADDRESS 130 E Fay

Date of filing 19____

Per _____ Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 22520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22520

CERTIFICATE OF DEATH

100-00

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gus Shaffer

(a) RESIDENCE NO. 100 N. Front St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address [redacted] Woods

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

BALTIMORE CITY HOSPITALS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 22, 1927, that I last saw him alive on May 21, 1927, and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R. Hooper Smith, M. D.

May 22 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial May 24 1927

20 UNDERTAKER [redacted] ADDRESS [redacted] Baltimore

MAY 23 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22521

E 22521

CERTIFICATE OF DEATH

185

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 626 W. North Avenue St. 13-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Gaddess Kefauver

(a) RESIDENCE NO. 626 W. North Avenue St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 9 mos. 11 ds. How long in U. S. if of foreign birth 84 yrs. 9 mo 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Mason Kefauver

6 DATE OF BIRTH (month, day, and year)
August-11-1842

7 AGE	Years	Months	Days
	84	9	11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexandra Gaddess

11 BIRTHPLACE OF FATHER (City or town) ? ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary A. Gaddess

13 BIRTHPLACE OF MOTHER (city or town) ? ?
(State or country) Virginia

14 Informant Mr. Webster M. Kefauver (son)
(Address) Tudor Hall Apts., City.

15 Filed MAY 23 1927 19

C. HAMPSON JONES, M. D. Registrar

By Rtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23-1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 7 1927 to May 23 1927

that I last saw her alive on May 22 1927

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

Fracture of Left Hip (Femur)

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Chaires, M. D.

19 (Address) 1500 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Greenmount Cemetery

Date of Burial May-25-27

20 UNDERTAKER STEWART & BROWEN COMPANY
(WILLIAM F. BROWEN, Successor)

ADDRESS 100 W. NORTH AVE

MAY 23 1927

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

E 22522

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22522

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3300 Walbrook ave ST., 15-67 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mc Carey

(a) RESIDENCE NO. 3300 Walbrook ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — dy. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Mc Carey

6 DATE OF BIRTH (month, day, and year): July 23-1863

7 AGE: Years 63 Months 10 Days 1 29 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Martin O'Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Joseph Mc Carey 3300 Walbrook Ave

15 C. HAMPSON JONES, M. D. Registrar

23 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to May 22, 1927

that I last saw h[illegible] alive on May 20, 1927.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis, Cardiac Dilatation

CONTRIBUTORY (Secondary) (duration) yrs. 5 mos. [illegible] ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James R Hattenbury M. D.

5/23, 1927 (Address) 1724 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: May 24 1927

20 UNDERTAKER: Chas S. Brause & Son — ADDRESS: 118 W Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Langford

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22523 146 E 22523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

City of BALTIMORE: (No. St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Langford

(a) RESIDENCE NO. 115 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Langford

6 DATE OF BIRTH (month, day, and year) March 12, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	29	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Holmes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah DeShield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Reads

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Y 23 1927 APW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 19 27

17

I HEREBY CERTIFY, That I attended deceased from May 2 19 27 to May 21 19 27

that I last saw h.e.r. alive on May 21 19 27

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

① Puerperal Infection

② Post Operative Hemorrhage - >24 hrs

③ Toxaemia of pregnancy - ?

①+② - (duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY ① Premature rupture of membranes

(Secondary)

② Generally Contracted rhachitic pelvis causing absolute dystocia (duration) ① ....yrs. ....mos. 7 ds.

② Since childhood

18 Where was disease contracted

If not at place of death? In patients home

Did an operation precede death? yes Date of 5/20/27.

Was there an autopsy? yes.

What test confirmed diagnosis? ....

(Signed) J. R. Hoerner., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Antony Cemetery May 25 1927

20 UNDERTAKER ADDRESS

Robert E. Hilton 1515 McCulloh

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22524

E 22524

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. Hut St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Manuss

(a) RESIDENCE NO. High Falls St. N. C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maud

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Car.

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER — Pettys

13 BIRTHPLACE OF MOTHER (city or town) N. Car.

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

MAY 23 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch- 24 1927, to May 23, 1927, that I last saw h[illegible] alive on May 23, 1927, and that death occurred, on the date stated above, at 2 30 a- m.

The CAUSE OF DEATH* was as follows:

Pneumonia-

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Encephalitis lethargica

(duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Ruth F. Fairbank, M. D.

, 19 (Address) J. Hopkins Hosp-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hallsboro N C — Date of Burial 5/23/27

20 UNDERTAKER Joseph ahrens — ADDRESS 221 Bway

MAY 23 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22525 E 22525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1837 North Washington Street REGISTERED NO. C

CITY OF BALTIMORE: (No. Michael J. Mulcrone St. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1837 North Washington Street St.; 1 yrs. mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. PHYSICIANS should state EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, March 17th 1858, 1 (Month) (Day) (Year)

7-AGE, 69 — 70 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Antique Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Patrick Mulcrone

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Julia Bolton

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia G. Magness

(Address) 14 East Read St.

15-

Filed 5-23, 1927 C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May--22nd. 1927, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1924, to May 22 1927, that I saw h-- alive on May 21 1927, and that death occurred, on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Sclerosis

(Duration) yrs. mos. ds.

(Signed) Wm H. Magness M. D.

5-22, 1927 (Address) 14 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, May 24, 1927

20-UNDERTAKER Wendell Ruppel — ADDRESS Town

23 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22526

E 22526

CERTIFICATE OF DEATH.

REGISTERED NO. 122-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 1032 Granby St. 3-5 Ward)

(If death occurred In a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Guiliano

(a) RESIDENCE NO. 1032 Granby St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Justina Guiliano

6 DATE OF BIRTH (month, day, and year): July 1st 1874

7 AGE — Years: 52 — Months: 10 — Days: 21 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer: Himself

9 BIRTHPLACE (city or town)

(State or country): Italy

PARENTS

10 NAME OF FATHER: Ermolao Guiliano

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Theresa Bendolino

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant: John Costantino

(Address) 1195 Central ave

15 Filed 5 23 1927 — 16 C. HAMPSON JONES, M. D. Registrar

Per R P P

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Hypertaphic Cirrhosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) myocarditis Toxiblatter

(duration) yrs. mos. ds.

(Signed) James M Gordon M. D.

(Coroner)

5/21 1927 (Address) 7002 Chases

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — Date of Burial: May 25 1927

20 UNDERTAKER: Wendell Piffelson — ADDRESS 378 N

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22527

E

CERTIFICATE OF DEATH.

188-106

E 22527

1-PLACE OF DEATH

City of BALTIMORE: (No. Keywick & Colesprug Ave St. 15-21 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Gross

(a) RESIDENCE NO. 615 Collett St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Virginia Gross.

6 DATE OF BIRTH (month, day, and year) 6/25/89

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Employed

(c) Name of employer: A. Hart Cushell Co Inc

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Richard Gross.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth A Bresee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Virginia Gross.

(Address) 615 Collett

15 Filed 2 3 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia & Lead Poisoning

Contributory Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Morrissey M. D.

(Coroner)

May 23, 1927 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peter Cemetery Date of Burial: May 24 1927

20 UNDERTAKER: Thomas G Nelson ADDRESS: 730 Preston St

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 M.L. Santuoro Dandeuno (McFeller)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22528

CERTIFICATE OF DEATH.

E 22528

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattis Dandeuno Santuoro.

(a) RESIDENCE NO. 129 S. Central ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 96 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1st 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer City Balto.

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Dominick Dandeuno

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Steve Cotile

(Address) 310 S Central ave

Filed MAY 31 1927 (Registrar) G. HAMPSON JONES M. D.

By N R H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 5 hrs.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

5-21-1927 (Address) Tower Chambers

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

129 S Central ave

Former or usual residence 129 S Central ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial May 23 1927

20 UNDERTAKER Rudell & Lippert ADDRESS 3101 Eden St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22529
1-PLACE OF DEATH

E 22529
REGISTERED NO.

City of BALTIMORE: (No. 1511 W. Mulberry 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank P. Thomas

(a) RESIDENCE NO. 1511 W. Mulberry Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rachael M. Thomas

6 DATE OF BIRTH (month, day, and year) March 21st 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ex-Park Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City—Carroll Park

9 BIRTHPLACE (city or town)
(State or country) France

PARENTS

10 NAME OF FATHER Adolph Thomas
11 BIRTHPLACE OF FATHER (city or town)
(State or country) France
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant Rachael M. Thomas
(Address) 1511 W. Mulberry St

15 Filed....., 19..... Registrar

MAY 24 1927 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) ex one mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Hoffman M. D.
(Coroner)
(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse Side for Additional Data)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial May 25th 27

20 UNDERTAKER J. A. Edwards — ADDRESS 763 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22530

CERTIFICATE OF DEATH.

REGISTERED NO. E 22530

1-PLACE OF DEATH Mt St. Joseph's College

City of BALTIMORE: (No. Frederick Ave St. 28-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Shea

(a) RESIDENCE NO. Mt St Jos College Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 29-1878

7 AGE: Years 48 | Months 9 | Days 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): College

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Rev Dunstan

(Address) Mt St Jos. Colle

15 Filed MAY 24 1927 19

C. HAMPSON JONES, M. D.

Registrar

Per K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 23-27

17 I HEREBY CERTIFY, That I attended deceased from May 20th 19 27, to May 23 19 27

that I last saw h.. alive on May 23 19 27,

and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Here

If not at place of death! —

Did an operation precede death! — Date of —

Was there an autopsy? no

What test confirmed diagnosis! Typical symptoms

(Signed) H. A. Wall, M. D.

5/25 19 27 (Address) Emmitsburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: May 29 1927

20 UNDERTAKER: F. A. Wanner & Son ADDRESS: 703 Hanover St

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22531

CERTIFICATE OF DEATH.

90

E 22531

1-PLACE OF DEATH 109 S. Calhoun

REGISTERED NO.

CITY OF BALTIMORE: (No. 19-29 St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ellen Lehrer

(a) RESIDENCE. No. 109 S. Calhoun St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late John F. Lehrer

6 DATE OF BIRTH (month, day, and year) May 1, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Housewife. 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John A. Ahern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Lehrer
(Address) 109 S Calhoun St.

15 Filed MAY 24 1927 19 HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 . 1926. to May 21 . 1927.

that I last saw h alive on May 21 . 1927.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Flo Lanup, M. D.

19 (Address) 904 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/25 '27

20 UNDERTAKER Harry H Nitzke

ADDRESS 1521 N Eutaw St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22532

CERTIFICATE OF DEATH.

E 22532

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Earl Bryant

(a) RESIDENCE No. 1837 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced (a) HUSBAND of (b) WIFE of Louise Bryant

6 DATE OF BIRTH (month, day, and year) Jan 6 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
32	33	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Louise Bryant (Address) 1827 Mc Henry St

15 MAY 24 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/27 19

17 I HEREBY CERTIFY, That I attended deceased from 5/16/27, 19, to 5/21/27, 19,

that I last saw h/ alive on 5/21/27, 19,

and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) Sudden ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL May 27 1927

20 UNDERTAKER Harry H Witzke ADDRESS 753 W Lombard St

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22533

CERTIFICATE OF DEATH

114

REGISTERED NO. E 22533

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 Druid Hill Ave. St. 17-25 Ward)

2-FULL NAME Juanita Williams.

(a) RESIDENCE NO. 516 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8-1921

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6		13 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Harry Williams

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Juanita Dixon

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Pacilla Dixon

(Address) 516 Druid Hill Ave

15 Filed 19

Per Registrar

C. HAMPSON JONES, M. D.

12.4 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15th 1927, to May 22 1927

that I last saw h[illegible] alive on May 22 1927

and that death occurred, on the date stated above, at 3-40 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Eastern Cemetery	May 25 1927
20 UNDERTAKER	ADDRESS
Chas. W. Johnson	416 N. Carrollton

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22534

CERTIFICATE OF DEATH

E 22534 REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Armstrong

(a) RESIDENCE NO. 1005 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 21-26

7 AGE — Years: 1 — Months: 2 — Days: — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore (State or country)

PARENTS

10 NAME OF FATHER: Rufus Armstrong

11 BIRTHPLACE OF FATHER (City or town): md. (State or country)

12 MAIDEN NAME OF MOTHER: Annie Ridout

13 BIRTHPLACE OF MOTHER (city or town): Md. (State or country)

14 Informant: Rufus Armstrong (Address) 1005 N. Stricker

15 Filed MAY 24 1927 19 C. HAMPSON JONES, M. D. Registrar

Dep.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 1927 to May 21 1927 that I last saw her alive on May 21 1927 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 (2) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John W. Garrett, M. D.

5-22-1927 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Date of Burial: May 24 1927

20 UNDERTAKER: Wm. H. Chase Son ADDRESS: [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22535

CERTIFICATE OF DEATH.

E 22535

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1316 W. Mosher St., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilkins

(a) RESIDENCE NO. 1316 W. Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Jno. Wilkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C

14 Informant Rosa Wilkins

(Address) 1316 Mosher

15 Filed ..... 19 ..... Registrar

MAY 24 1927

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/1927

17 I HEREBY CERTIFY, That I attended deceased from 5/20/1927, to 5/22/1927, that I last saw him alive on 5/22/1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hurley M. D.

(Address) 917 Eilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Date of Burial May 24 1927

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1420 Mosher

Use ink and write carefully; supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22536 — CERTIFICATE OF DEATH. — E 22536

+ 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1517 W Lanvale (St.) 16 22 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Henson

(a) RESIDENCE No. Taylor Island Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22-72

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dan'l Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Campher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Amelia Chester

(Address) 517 W Lanvale

15 Filed MAY 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to May 23, 1927, that I last saw her alive on May 22, 1927, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with R Hemiplegia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? Taylor Island Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Dr G W Bernard, M. D.

5-23 1927 (Address) 708 Enson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taylor's Island Md — DATE OF BURIAL May 24 1927

20 UNDERTAKER Sam'l N. Chase & Son — ADDRESS Fos Maker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22537

CERTIFICATE OF DEATH.

74-001

E 22537

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1737 Mc Cubbin ST. (WARD) 64

2-FULL NAME Elezibeth Edwards

(a) RESIDENCE NO. 1737 Mc Cubbin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Edwards

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 59 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rock Point Md

PARENTS

10 NAME OF FATHER: Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rock Point Anne Arundel Md

12 MAIDEN NAME OF MOTHER: Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Arundel Co. Md

14 Informant: James Albert

(Address) 1737 Mc Cubbin St

15 Filed MAY 24 1927 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/21 1927

17

I HEREBY CERTIFY, That I attended deceased from 5/2 1927 to 5/21 1927

that I last saw h alive on 5/20 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senile Bronchitis and Arthritis

Hypertension (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Hanley, M. D.

5/22 1927 (Address) 1729 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 5/24 1927

20 UNDERTAKER: Byron Wright

ADDRESS 1218 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22538 — 129 — E 22538

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Lowman

(a) RESIDENCE NO. 746 N. Montford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Lowman

6 DATE OF BIRTH (month, day, and year): Oct 10, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: A. Tom Runge

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Josephine Sobec

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Austria

14 Informant: John W. Lowman

(Address): 229 N. Duncan St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAY 24 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-23-27

17 I HEREBY CERTIFY, That I attended deceased from 5-17, 19 27, to 5-23, 19 27, that I last saw h[illegible] alive on 5-23, 19 27, and that death occurred, on the date stated above, at 5 00 p m.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) Max H. Krenfeld, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn ~~Hebrew Cemetery~~ Date of Burial May 26 19 27

20 UNDERTAKER: Wm. Cook ADDRESS 502 E. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

E 22539

CERTIFICATE OF DEATH

E 22539

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2532 N Charles St., 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grant Howell Stockham

(a) RESIDENCE NO. 2532 N Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 ~~Life~~ mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 9-1889

7 AGE: 38. Years: 37 Months: 11 Days: 13 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Camden

(State or country): N. J.

PARENTS

10 NAME OF FATHER: Grant Stockham

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Camden N.J.

12 MAIDEN NAME OF MOTHER: Clara E. Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Camden N. J.

14 Informant: Grant Stockham

(Address) 2532 N Charles St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

Per .....

MAY 24 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926 to May 22, 1927

that I last saw h[illegible] alive on May 22, 1927

and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver, Bladder

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 112 W 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Park Wood Cemetery — Date of Burial: May 24 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: N Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22540

CERTIFICATE OF DEATH.

E 22540

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore & St.Paul Sts. St. 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Linda A.Crouch.

(a) RESIDENCE NO. Chestertown, Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred on visit. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced, (or) WIFE of James W.Crouch.

6 DATE OF BIRTH (month, day, and year) March 18, 1866.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Kent Co.Md.

PARENTS

10 NAME OF FATHER Edward J.Watson.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware.

12 MAIDEN NAME OF MOTHER Sarah A.Simmons.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware.

14 Informant James W.Crouch.(husband)

(Address) Chestertown,Md.

15 Filed MAY 24 1927, 19 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Struck and knocked down by a street car.
Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs, ...mos. .....ds.

(Signed) H. M. Reinhardt M. D.
(Coroner)

5/24 1927 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md. Date of Burial 5/25 1927

UNDERTAKER Chas. H. Thomas & Brown Company ADDRESS 1085 N. Howard St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Gray

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22541

CERTIFICATE OF DEATH

31 E 22541

1-PLACE OF DEATH

REGISTERED NO. 1529

City of BALTIMORE: (No. Baltimore City Hospitals St., (W.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Gray

(a) RESIDENCE NO. 867 Lemon st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address) Hospital Records

15 Filed , 19 C. HARRISON JONES, M. D. Registrar

Per

1384

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25 27, 19 , to May 21 27, 19 ,

that I last saw him alive on May 21, 19 27,

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatteano, M. D.

5-21-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Hospital

MAY 1927

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 ✓ E 22542

CERTIFICATE OF DEATH

E 22542

REGISTERED NO. 15-60

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Balto City Hospitals St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius E Jacobs -

(a) RESIDENCE NO. 1917 N. Bentalou St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Ellen M Jacobs

6 DATE OF BIRTH (month, day, and year): March 10 1874

7 AGE: 85 Years 6 Months 2 Days 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Virginia Dietrich

(Address) Guyon Oak ave

MAY 24 1927

HAMPSON JONES, M. D. Registrar

Per RRC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 21, 1927

that I last saw him alive on May 21, 1927

and that death occurred, on the date stated above, at 7.05 m.

The CAUSE OF DEATH* was as follows: Senile Gangrene Right Leg - (Type Diabetes)

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Lenual Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examined

(Signed) H Blauvelt, M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — Date of Burial: 5-24 1927

20 UNDERTAKER: Mrs Chas A J Pohlé — ADDRESS: 600 N Arlington Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22543

CERTIFICATE OF DEATH.

REGISTERED NO. E 22543

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Belair Road ST. 27-41 WARD)

2-FULL NAME Fannie Galitzer

(a) RESIDENCE NO. 1316 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 - 1913

7 AGE — Years: 13 — Months: 5 — Days: 21 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) [redacted]

PARENTS

10 NAME OF FATHER Hirsh Galitzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Sokol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 Eutaw St

15 Filed MAY 24 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1927

17 I HEREBY CERTIFY, That I attended deceased from , 1926 , to May 23 , 1927 .

that I last saw h[illegible] alive on May 20 , 1927 .

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lucille Liberles, M. D.

5-23, 1927 (Address) 2407 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem DATE OF BURIAL 5/24 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22544

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1886 006

E 22544

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Keswick + Coldspring St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Brown

(a) RESIDENCE NO. 135 N. Haight St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	About 38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Employed

(c) Name of employer: A

9 BIRTHPLACE (city or town)

(State or country): Unknown

PARENTS

10 NAME OF FATHER: "

11 BIRTHPLACE OF FATHER (city or town)

(State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): "

14 Informant: Health Dept

(Address)

Filed MAY 24 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Injuries to Head + Body

Head + Fracture of Base of Skull

while working on fallen tree

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Morrison M. D.

(Coroner)

5/23. 1927 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: May 26 1927

20 UNDERTAKER: E. Leroy Stiffler — ADDRESS: 125 E. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22545 CERTIFICATE OF DEATH. X 31 E 22545

1-PLACE OF DEATH U.S. Marine Hospital No 1 REGISTERED NO.

CITY OF BALTIMORE: (No. 1 Baltimore, Md. ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pete Bethea.

(a) RESIDENCE No. 1036 Leadenhall St Baltimore, Md. ST., S. 6. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 18, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	22 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Merman

(c) Name of employer S/S Ontario

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Clarence Bethea

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Un Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant self (Address)

15 Filed MAY 24 1927 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1927, to May 22, 1927, that I last saw h— alive on May 22, 1927, and that death occurred, on the date stated above, at 7-15 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonary

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Laboratory tests & Physical findings

(Signed) Lew Benton A.A. Surgeon U.S.P.H.S., M. D.

5-24, 1927 (Address) U.S. Marine Hospital No 1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillon S. C. DATE OF BURIAL May 24 1927

20 UNDERTAKER E. LeRoy Stuffle ADDRESS 1555 Main Ave

TION is very important. See instructions on back of Certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22546

CERTIFICATE OF DEATH.

E 22546

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. WARD 28-63

2-FULL NAME Mary Ellen Mackin

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD Woodlawn

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 3 yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 5 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
75	76	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edmund Mackin

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johnna Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mt Hope Friends Mt Hope Retreat

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to May 24, 1927, that I last saw her alive on May 23, 1927, and that death occurred, on the date stated above, at 6.15 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(acute Cardiac Dilatation)

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Deliberation

Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn - Md.

DATE OF BURIAL May 27, 27.

20 UNDERTAKER J. STUART & MCWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.–200 Bks.

E 22547

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-003

E 22547

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert Ste. St., 249 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anita Jane Troland

(a) RESIDENCE NO. Popular Lane, Catonsville St. Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 16, 1921

7 AGE: Years 5 Months 6 Days 7 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER Capt. C. B Troland

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Conn.

12 MAIDEN NAME OF MOTHER Marian Bragaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Conn.

14 Informant Hospital Records

(Address) C. HAMPSON JONES, M. D.

15 Filed ....., 19..... Per ..... Registrar

JUN 24 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 23, 1927, that I last saw h.. alive on May 23, 1927 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis.

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Spina bifida

(duration) life yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? partial

What test confirmed diagnosis? clinical, laboratory & autopsy

(Signed) Frankl. Smith, Jr., M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New London Conn. Date of Burial 5/24 19 27

20 UNDERTAKER: Wm Cook ADDRESS Sole Mill

Fill in above spaces carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22548

CERTIFICATE OF DEATH.

E 22548

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2030 E. 31 St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel F. Sommerwerk

(a) RESIDENCE NO. 2030 E. 31st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Sommerwerk

6 DATE OF BIRTH (month, day, and year): Aug 23 1844

7 AGE: Years 83 | Months 9 | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 10 years

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: George Sommerwerk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Wieghardt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Raymond L. Reisenweber

(Address): 1734 Chilton St

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/20 1927 to 5/23 1927, that I last saw him alive on 5/23 1927, and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Stasis

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Leupold, M. D.

, 19 (Address) 1320 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: May 25 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

24 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22549

CERTIFICATE OF DEATH.

161-001

E 22549

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2626 Ashland Ave St., 12 Ward)

2-FULL NAME Thomas Guarnaccia

(a) RESIDENCE NO. 2626 Ashland Ave St. ____ Ward

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year): May 20 / 27

7 AGE: Years ___ / Months ___ / Days 3 / IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Guarnaccia

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Lombardi

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: F. Antigone

(Address): 2942 E. Fayette

15 Filed ____, 19____ Registrar

C. HAMPSON JONES, M. D.

MAY 24 1927 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 23 - 1927

17

I HEREBY CERTIFY, That I attended deceased from May 20, 19 27, to May 23, 19 27, that I last saw h.... alive on May 23, 19 27, and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

Tumor of liver

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. Antigone, M. D.

, 19 (Address) 2942 E. Fayette.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent — Date of Burial: May 24 1927

20 UNDERTAKER: Frank V. Lefitore — ADDRESS: 2 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22550

CERTIFICATE OF DEATH

129 E 22550

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Md. General Hospital (St.) (Ward) 17-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kachey

(a) RESIDENCE NO. 5424 Harford Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5-2-1885

7 AGE — Years: 42 — Months: — Days: 21 20 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Charles Kachey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Canada.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records (Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

24 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-22- 1927, to 5-23 19 27

that I last saw him alive on 5-23 19 27

and that death occurred, on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Uremia (7 days)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation 12 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: 5/25 1927

20 UNDERTAKER: Leonard J. Roch — ADDRESS: Lafayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22551

HEALTH DEPARTMENT—CITY OF BALTIMORE

Forest View Park

CERTIFICATE OF DEATH.

1827 E 22551

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Park St. 8-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie F. Kidd

(a) RESIDENCE NO. 3203 Lyndale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 24 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22	X	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wilbert F. Kidd.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Amelia C. Zinke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Wilbert F. Kidd

(Address) 3203 Lyndale Ave.

15 DATE 24 1927

16 C. HAMPSON JONES, M. D.

Per M.K.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows*

Accident

Multiple Fractures (one)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

Signed M. D.

(Coroner)

24 19 (Address) 1143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial May 25 19 27

20 UNDERTAKER Robt. J. Turner, Inc. ADDRESS 1042 N. Broadway Balto. Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22552

CERTIFICATE OF DEATH

+ 12 E 22552

REGISTERED NO. 3424

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude Cowan

(a) RESIDENCE NO. Cleistertown Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-21-1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk

(State or country) N. Y.

PARENTS

10 NAME OF FATHER John Cowan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Lychia Cowan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Hospital Records

(Address)

15 Filed MAY 24 1927 C. HAMPSON JONES, M. D. Registrar

Per MRB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-9- 1927 to 5-23 1927

that I last saw her alive on 5-23 1927

and that death occurred, on the date stated above, at 5:03 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis with interstitial Carcinoma & Hypostasis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norwood. N. Y. Date of Burial May 24 1927

20 UNDERTAKER Mrs Geo. John W. Tenfelde Son ADDRESS 801 W Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22553 (2)

CERTIFICATE OF DEATH.

E 22553

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 32

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 8-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martini Lee Bayne

(a) RESIDENCE NO. 1826 N. Castle St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-30-26

7 AGE Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
1 yr.		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Martini Bayne

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Susie Carbelin

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Records — JOHNS HOPKINS HOSPITAL

(Address) C. HAMPSON JONES, M. D.

15 MAY 24 1927, 19

Per ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1927, to May 23, 1927, that I last saw him alive on May 23, 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ____ yrs. ____ mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Rothman, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial 5/25 1927

20 UNDERTAKER Margaret J. Flynn ADDRESS 1020 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22554 E 22554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 8 (WARD)

REGISTERED NO. 100-201

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amanda Marlen

(a) RESIDENCE NO. 2830 Clifton Park Terrace Balto Md.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: George C. Martin

6 DATE OF BIRTH (month, day, and year): Aug. 30, 1898

7 AGE — Years: 28 — Months: 8 — Days: 24 — If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: August Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hermine Hube

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Geo. C. Martin (Address) 2830 Clifton Park Terrace

15 Filed ... 19 ... Registrar C. HAMPSON JONES, M. D.

2-4-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/24/27 19

17 I HEREBY CERTIFY, That I attended deceased from 5/23/27, 19, to 5/24/27, 19, that I last saw him alive on 5/24/27, 19, and that death occurred, on the date stated above, at 10.10 A.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Splenodal Sinusitis.

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture & Xray

(Signed) E R Muller, M. D.

19 ... (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 5/27 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 1422 Light St

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22555 × 51 E 22555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25-72 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Litchfield

(a) RESIDENCE NO. Ellicott City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H Litchfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) not given

12 MAIDEN NAME OF MOTHER Rebecca " Dalckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. H. Litchfield
(Address) C. HAMPSON JONES, M. D.

15 Filed ..... 19 ..... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1927, to 5-24, 1927, that I last saw her alive on 5-24, 1927, and that death occurred, on the date stated above, at 7 50 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Endocarditis

(duration) ..... yrs. ..... mos 45 ds.

CONTRIBUTORY (Secondary)
Bronchopneumonia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W P M Brodie, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Mark Cem. DATE OF BURIAL May 26 1927

20 UNDERTAKER Easton Lore, Ellicott City ADDRESS

TION is very important. See instructions on back of certificates.

24 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22556 90 E 22556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO. 90-69

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter E. Henderson

(a) RESIDENCE NO. 2636 Dulaney ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Florence Henderson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 3rd Corps Area

(c) Name of employer

9 BIRTHPLACE (city or town) San Francisco (State or country) Cal.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Anna F. Henderson (Address) 2636 Dulaney St

15 Filed MAY 25 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1927, to May 22, 1927, that I last saw h[illegible] alive on May 22, 1927, and that death occurred, on the date stated above, at 3.00 p m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy
Mitral stenosis and insufficiency
Pulmonary infarct
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jacob Reimen, M. D.

5/23 1927 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL May 25, 27

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto St

FAILURE TO FILL IN ALL ITEMS IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22557 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 135 E 22557

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) 13-57 ST., (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel G. Miller

(a) RESIDENCE No. 836 W 34th St ST., WARD C
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, (Widowed,) or divorced HUSBAND of (or) ~~WIFE of~~: Susannah Miller

6 DATE OF BIRTH (month, day, and year): July 29, 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): R R
(c) Name of employer: Conductor

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Susannah Miller
(Address): ~~836 W 34th St~~

15 Filed MAY 25 1927 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23/27

17 I HEREBY CERTIFY, That I attended deceased from 5/13/27, 19, to 5/23/27, 19, that I last saw him alive on 5/23/27, 19, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis - Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/14/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs.

(Signed) A. Wallace Walker M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cem. DATE OF BURIAL: May 26, 1927.

20 UNDERTAKER: Chenoweth Son ADDRESS: 3615 Eastern Ave.

SECTION OF REGISTRAR on public terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 E 22558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 W. Hamburg ST. 23-31 WARD)

2-FULL NAME Baby Holmes

(a) RESIDENCE NO. 228 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9hrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 23 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or ~~min~~.
9hrs	0	0	~~1~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Roy Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundal Co. Maryland

14 Informant Mrs. Martha Holmes

(Address)

15 Filed MAY 25 1927 4386 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17

I HEREBY CERTIFY, That I attended deceased from 9.45AM May 23, 1927 to 7PM May 23, 1927, that I last saw her alive on 9.45AM May 23, 1927 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 9/24 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Alexander Novey, M. D.

, 19 (Address) 1416 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

G. HAMPSON JONES, M. D.

JOHNS HOPKINS HOSPITAL

MAY 24 1927

FROM is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22559

CERTIFICATE OF DEATH

E 22559

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hosp (C.B.) St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Hines

(a) RESIDENCE NO. 624 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide Hines.

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE — Years: 25 — Months — Days — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Carolina.

PARENTS

10 NAME OF FATHER: Richard Hines

11 BIRTHPLACE OF FATHER (City or town) (State or country): S. Carolina.

12 MAIDEN NAME OF MOTHER: Nellie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant (Address): Bay View Hospital

15 Filed MAY 25 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 21 1927. to May 22 1927.

that I last saw him alive on May 22 1927.

and that death occurred, on the date stated above, at 3.55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) W. E. Gatlin, M. D.

5/22/ 1927 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va. — Date of Burial: May 25 1927

20 UNDERTAKER: Leonard Whalen — ADDRESS: 309 Fayette ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22560
1-PLACE OF DEATH

E 22560
REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sparrow , Jr

(a) RESIDENCE NO. 520 S. Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct 22/1915

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	11	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Sparrow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER S. Pajkowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant John Sparrow Sr
(Address) 520 S. Ann St.

15 Filed 19
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured skull & other injuries
Run over by autotruck, at Eastern Ave & Exeter St.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Pollitt M. D.
(Coroner)

19 (Address) 5/25/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial May 26 1927

20 UNDERTAKER F. W. Ozazewski ADDRESS 1930 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E. HAMPSON JONES, M. D.

APR 25 1927

Spec.—11-12-23—M&T—500 Blks.

E 22561 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22561

CERTIFICATE OF DEATH.

10-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 4-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Grover

(a) RESIDENCE NO. 752 W. Fayette St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 26, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert F. Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Mabel Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Robert F. Grover

(Address) 752 W. Fayette St

15 Filed MAY 25 1927 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to May 24, 1927, that I last saw him alive on May 24, 1927, and that death occurred, on the date stated above, at 4 45 p. m.

The CAUSE OF DEATH* was as follows:

Nasal + Laryngeal Diphtheria

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of May 24, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical & por. culture

(Signed) Myron G. Tull, M. D.

5/25, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL May 26 1927

20 UNDERTAKER A. Howard Evans ADDRESS 358 Fort Ave

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 22562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 22562

1-PLACE OF DEATH

REGISTERED NO. 13-59

City of BALTIMORE: (No. 2323 Eutaw Place St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannette Arnstein

(a) RESIDENCE NO. 2323 Eutaw Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Arnstein

6 DATE OF BIRTH (month, day, and year) Dec. 18th. 1855.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chicago.

(State or country) Ill.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Frank

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Samuel Frensdorf

(Address) 2323 Eutaw Place

MAY 25 1927 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1926, to May 24, 1927, that I last saw h[illegible] alive on May 24, 1927, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes - atero-sclerosis and angina pectoris.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Data of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lutz, M. D.

May 25 1927 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago, Ill. Date of Burial May 25, 1927

20 UNDERTAKER David Sondheim ADDRESS 1520 W. Mt. Royal Ave.

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 22563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22563

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 830 Paca St. 21-29/59-002 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred E Hahn

(a) RESIDENCE NO. 830 Paca St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): 5/22/27

7 AGE: Years ✓ Months ✓ Days 1 2 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Edith Dreier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: M. Thomas Hahn. (Address) 862 Washington Blvd

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/24/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1927, to 5/24, 1927, that I last saw h alive on 5/24/, 1927, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Failure of Foramen Oval to close

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Davis M. D.

19 (Address) 1507 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 5/25/ 1927

20 UNDERTAKER: Foley & Cowan Inc. — ADDRESS: 901 Hollins St.

TION is very important. See instructions on back of certificates.

C. CLAWN

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — E 22564 — REGISTERED NO. E 22564

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST. 2000 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Brown

(a) RESIDENCE NO. 1085 S. Callowhill ST., [illegible] WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Paul Brown

6 DATE OF BIRTH (month, day, and year) Feb 25th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mid Given

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mr. P. Schlesinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bernbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. P. Schlesinger (Address) 1085 S. Calhoun

15 Filed MAY 25 1927 Registrar HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1927, to 5-23, 1927.

That I last saw her alive on 5-23, 1927.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

endometritis

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. findings

(Signed) W P [illegible] Bush, M. D.

, 19 (Address) 1 Wash Boulev

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 26 1927

UNDERTAKER P. B. Weisert — ADDRESS 1850 W Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 22565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

E 22565
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 Walbrook Ave. ST.) (2567 WARD)

2-FULL NAME Ella A. Classen

(a) RESIDENCE No. 3406 Walbrook Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. H. Classen

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min
	83	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lamb Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Kellie M. Snyder
(Address) 3406 Walbrook Ave

15 Filed 25 1927, 19 Pm
C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 23, 1927.

that I last saw h.T alive on May 23, 1927.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Senile arteriosclerosis with general debility.

(duration) ? yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Respiratory paralysis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Hayden Cole, M. D.

5/25, 1927 (Address) 7707 Limerick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL May 26 1927

20 UNDERTAKER Wm. Tuckner Sons ADDRESS North Ave

Spec.—1-12-23—M&T—500 Bks.

E 22566

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th St + Cedar Ave. WARD) 13-52 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Anne Beck

(a) RESIDENCE NO. Home for Incurables - 40st. + Cedar Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Beck

6 DATE OF BIRTH (month, day, and year) Aug. 19-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Halifax. N. S.

PARENTS

10 NAME OF FATHER Wm. Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Knowland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Halifax N.S.

14 Informant Elizabeth Vincent

(Address) 118 Old Liberty Ave

15 5 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-9-, 1926, to May 24, 1927, that I last saw her alive on May 24, 1927 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) over 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis, Fractured femur over 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W W B Mayo M. D.

5/25 1927 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 28 1927

20 UNDERTAKER Chas. O. Evans & Son

ADDRESS 1181 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22567 E 22567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St. 11-15 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Roland

(a) RESIDENCE NO. 937 N. Calvert St. St. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day....hrs. or....min.
		1 day -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Thomas Roland

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Lula Miller

13 BIRTHPLACE OF MOTHER (city or town) N. Y.

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

MAY 25 1927 1388 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-20-27

17 I HEREBY CERTIFY, That I attended deceased from 5-19-27, 19..., to 5-20-27, 19...,

that I last saw h.e.s. alive on 5-20-27, 19...,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ____

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? yes

What test confirmed diagnosis? ____

(Signed) I. Ridgeway Trimble M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ____ Date of Burial 19

20 UNDERTAKER ____ ADDRESS ____

very important. See instructions on back of certificates. [illegible] is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22568

CERTIFICATE OF DEATH.

161-1902 E 22563

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St. 7-4 Ward)

2-FULL NAME Baby Young

(a) RESIDENCE NO. / St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 17, 1927

7 AGE: Years: / Months: Days: IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country)

PARENTS

10 NAME OF FATHER: Moses Young

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rosie Bagley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Records

(Address): Hopkins Hospital

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

5 1927 1390 ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to May 17, 1927,

that I last saw h.e.l. alive on May 17, 1927,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Contracted pelvis of mother causing difficult labor.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Koerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health

JOHNS HOPKINS HOSPITAL MAY 25 1927

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 22569

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22569

100-201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Thomas

(a) RESIDENCE NO. 426 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 [redacted]ORE CITY HO[redacted]

Infor[redacted] Records

(Address)

MAY 25 1927 19

1393 RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to May 22, 1927, that I last saw him alive on May 22, 1927, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Interstitial nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis! General & Laboratory

(Signed) C. Hampson Jones, M. D.

May 24 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

MAY 25 1927

C. HAMPSON JONES

UNIVERSITY OF MARYLAND

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22570 E 22570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hospls.

City of BALTIMORE: (No. Balto Md. St. 1637 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Williams

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. dy. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md.

15 Filed 19

5 1927 1394 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: 5-25

17 I HEREBY CERTIFY, That I attended deceased from 9-14, 1927, to 5-25, 19 27

that I last saw h/m alive on 5-24, 19 27

and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH was as follows:

Terminal Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis w/ Delerium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry [illegible] M.D.

5/25, 19 27 (Address) 1 Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

If very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22571

CERTIFICATE OF DEATH

102

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ricketts

(a) RESIDENCE NO. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (Write the word)
Male.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
33 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maine

(State or country)

PARENTS

10 NAME OF FATHER Wm Ricketts.

11 BIRTHPLACE OF FATHER (City or town) Maine

(State or country)

12 MAIDEN NAME OF MOTHER Jane. Reed.

13 BIRTHPLACE OF MOTHER (city or town) Maine.

(State or country)

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

MAY 23 1927 1395

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

5-22-

17 I HEREBY CERTIFY, That I attended deceased from 5-17- 1927 to 5-22- 1927

that I last saw him alive on 5-22- 1927

and that death occurred, on the date stated above, at 8 00 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Emphysema

Lt.

(duration) 10 days - ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 5-17-27

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Laboratory

(Signed) H. Blumgart M. D.

, 19 (Address) Balto City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22572

CERTIFICATE OF DEATH.

164

E 22572

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-4 Ward)

2-FULL NAME Elizabeth Flowden

(a) RESIDENCE NO. Preston & Valley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Rockville Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Unknown

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

May 24th

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1926, to _____, 19____, that I last saw h.r alive on May 22, 1927, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? ___ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) F. L. Adams, M. D.

May 24, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cesbury Cem. Date of Burial: May 27 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 775 Cathedral

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 22573

HEALTH DEPARTMENT—CITY OF BALTIMORE E 22573

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 275 W. 31 St. (St.) 17-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella J. Patton

(a) RESIDENCE NO. 275 W 31 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: William H. Patton

6 DATE OF BIRTH (month, day, and year): Sept 17—1859

7 AGE — Years: 67 — Months: 8 — Days: 7 8 — If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Wm N. Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizabeth Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Wm H Patton 275 W 31 St.

15 5 1927 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2 1927 to May 24 1927.

that I last saw h alive on May 24 1927.

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 9 days — yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 3 years mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) R B Norment M. D.

5.24. 1927 (Address) 1547 Charlestown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hawkdale — DATE OF BURIAL: May 26 1927

20 UNDERTAKER: A S Marshall — ADDRESS: 1539 Fall Rd

IMPORTANT. See instructions on back of certificates.

E 22574

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 22574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1827 (Street) Division St. (Ward) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Sayles

(a) RESIDENCE. No. 1827 Division St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert H. Sayles

6 DATE OF BIRTH (month, day, and year): Aug 1 1864

7 AGE: Years 62 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James F. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Matilda Doney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robert H. Sayles (Address): 707 E. 20th St. City

15 Filed MAY 26 1927 C. HAMPSON JONES, M. C. By H. Bond

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19 1927 to May 25 1927 that I last saw h[illegible] alive on May 24 1927 and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary): None known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Chas. J. Keller M. D.

5/26, 1927 (Address) 722 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lane L

DATE OF BURIAL: 5/28/1927

20 UNDERTAKER: Geo. E. Holland

ADDRESS: 1612 Druid Hill Ave

Print in very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22575

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22575

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH Colonial Hosp. 425 REGISTERED NO.

City of BALTIMORE: (No. 1122 W. Mounts St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. Nelson.

(a) RESIDENCE NO. (104 Eldorado Ave) 400 Cathedral St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.

6 DATE OF BIRTH (month, day, and year) Oct. 4–1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	77	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Customer to

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pratt Library

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Steven Nelson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Osheanner M. Hamilton

(Address) 400 Cathedral St

MAY 26 1927

J. C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 – 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/21 1927 to 5/25 1927

that I last saw h[illegible] alive on 5/24 1927

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY None

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Phys. Exam

What test confirmed diagnosis?

(Signed) John W. Wortham M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

Date of Burial 5/28/1927

20 UNDERTAKER Geo. H. Holland

ADDRESS 1618 Druid Hill Ave

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 22576

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22576

CERTIFICATE OF DEATH.

182

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Russell & Bush Sts. St., 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hoyle.(C.)

(a) RESIDENCE NO. 1825 N. Spring St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificate. PARENTS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 3, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment to which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Glencoe, Md.

10 NAME OF FATHER John Hoyle.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Tennesea.

12 MAIDEN NAME OF MOTHER Ella Wise.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Elsie Hoyle.(C) sister.

(Address) 1825 N. Spring St.

15 Filed ... 19 ... Registrar

MAY 25 1927 HAMPSON-JONES M

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall into the water while reaching for a ball.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

5/26 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Vaulsum Cem Date of Burial May 26/27

20 UNDERTAKER Daniel Easton ADDRESS 916 Bare

Spec.—1-12'23—M&T—500 Blks.

E 22577 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22577

CERTIFICATE OF DEATH 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 South Paca ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Navagruckis

(a) RESIDENCE No. 318 South Paca ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Stella Matacute

6 DATE OF BIRTH (month, day, and year) No. 1894

7 AGE 33 Years — Months — Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER J.Navagruckis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER U. Terleckute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Stella Navagruckis

(Address) 318 S Paca Street

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 . 1927 . to May 24 . 1927 . that I last saw him alive on May 24 . 1927 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Bloemer M. D.

5/26 . 1927 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 27. 1927

20 UNDERTAKER: John Grebliauckas J.G. — ADDRESS: 423 S Paca St

19 G HAMPSON JONES M D

Spec.—1-10-21—M&T—1500 Blks.

Congleton.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22578 — CERTIFICATE OF DEATH. — E 22578

23-32 101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 S Chester ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mose Congleton

(a) RESIDENCE NO. 1515 S Chester ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie E. Congleton

6 DATE OF BIRTH (month, day, and year) March 5 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	48	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address)

15 Filed ....., 19.... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to May 25, 1927, that I last saw h— alive on May 25, 1927, and that death occurred, on the date stated above, at 5—P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R.R. Campbell M. D.

May 25 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL May 27 1927

20 UNDERTAKER E. Schlosman Son

ADDRESS 1039 Hanover

MAY 26 1927 C. HAMPSON JONES, M. D.

FOR A very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22579

CERTIFICATE OF DEATH.

23-34 129

E 22579

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1406 Marshall. ST. (WARD)

2-FULL NAME Bessie M. Deck

(a) RESIDENCE NO. 1406 Marshall. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 2 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER J. T. A. Deck

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Zama B. Padgett

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Deck (Address) 1406 Marshall

15 Filed MAY 26 1927 Registrar HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10" 1926 to May 26" 1927, that I last saw h alive on 5/24/26 1927 and that death occurred, on the date stated above, at 5 P M

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Hypocordia

(duration) — yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hartman M. D.

1927 (Address) 1340 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harpers Ferry Harpers Ferry

DATE OF BURIAL 5/29 1927

20 UNDERTAKER J. Fenw. McCully

ADDRESS 130 E Fort

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22580

CERTIFICATE OF DEATH.

90 E 22580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2513 Madison ave ST., 13-54 WARD)

2-FULL NAME Goldie Levin

(a) RESIDENCE NO. 2513 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Levin

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Bruger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bailey Lehloffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Aaron Levin

(Address) 2513 Madison ave

15 Filed MAY 26 1927 HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 1919, to May 25, 1927, that I last saw her alive on May 25, 1927, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis stenosis
r insufficiency

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jacob Cohen, M. D.

5-26, 1927 (Address) 223 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Circle Cem

DATE OF BURIAL 5/26 1927

20 UNDERTAKER Jack Leurs

ADDRESS 1439 E Baltimore

Spec.—7-17-26—A Co.—200 Bks.

Wise

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22581

CERTIFICATE OF DEATH

× 45 ✓

E 22581

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO. 18-76

City of BALTIMORE: (No. ____ St., ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Charlotte E. Wise

(a) RESIDENCE NO. 934 W Fayette St. Rockingham P.O. Va St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ? mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. P. Wise

6 DATE OF BIRTH (month, day, and year) July 2nd 1851

7 AGE 45	Years 76	Months 10	Days 23	IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Harrisburg

(State or country) Virginia

PARENTS

10 NAME OF FATHER ? Gilmer

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant M. P. Wise

(Address) 934 W. Fayette St Balt.

15 Filed ____, 19 ____ C. HAMPSON JONES, M. D. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1926, to May 25, 1927, that I last saw h... alive on May 25, 1927, and that death occurred, on the date stated above, at 5:10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid.

(duration) ____ yrs. 5 mos. ____ ds.

CONTRIBUTORY (Secondary) mucous plaque syphilid.

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? Yes Date of 11-22-26

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam.

(Signed) Edward P. Harrison, M. D.

, 19 (Address) Woman's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisonburg Va — Date of Burial May 26 1927

20 UNDERTAKER George J. Smith — ADDRESS Hollins

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22582

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22582

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 N. Gilmor St., 19-27 Ward)

2-FULL NAME James E. Taylor

(a) RESIDENCE NO. 410 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Oct 2nd 1926

7 AGE: Years — Months 7 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John M. Taylor

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Eula Hornsby

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Eula Taylor

(Address) 410 N. Gilmor St

Filed May 26 1927, 19

C. HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained [illegible] find that said deceased came to death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Bronchio Pneumonia

(duration) .....yrs. —mos. 5 ds.

CONTRIBUTORY (Secondary)

Signed Thos. B. Hodson M. D.

(Address) Curtis Bay Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Wayne Pa. Date of Burial 1927

20 UNDERTAKER: Virginia A. Brooks ADDRESS 1463 N. Carey St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 22583

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 22583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Presbyterian Homes of Maryland REGISTERED NO. _____

City of BALTIMORE: (No. 822 N Conalton ave St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Jackson

(a) RESIDENCE NO. Presbyterian Homes St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 22 1845

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	82	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 66

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Jackson

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): unknown

12 MAIDEN NAME OF MOTHER: Rebecca Ann Howes

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): England

14 Informant: Home Records

(Address)

15 Filed: 26 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1926 to May 24, 1927, that I last saw h. alive on May 23, 1927, and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBITORY (Secondary) Apoplexy

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Arteria Cl

(Signed) J. M. Lehmeyer M. D.

(Address) 5729 1927 3407 Callaway ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Date of Burial: May 27 1927

20 UNDERTAKER: Chas. S. Black ADDRESS: 742 W. North ave

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Dr. Moran 516 Cathedral Street

E 22584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-02

E 22584

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1614 E Fat Ave (St.) 24-35 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frieda Stegman

(a) RESIDENCE NO. 1614 E Fat Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D Stegman

6 DATE OF BIRTH (month, day, and year): March 8 1854

7 AGE — Years: 73 Months: 2 Days: 22

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Annie E. Frenth (Address) 1614 E Fat Ave

15 Filed MAY 26 1927 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1924 to May 24 1927

that I last saw her alive on May 21 1927

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. G. Murr M. D.

May 25 1927 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: May 26 1927

PER UNDERTAKER: Williamson — ADDRESS: 502 E Fat Ave

very important. See instructions on back of certificates. NUMBER AND LETTER OF OCCUPATION IS

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22585

CERTIFICATE OF DEATH.

51

REGISTERED No. E 22585

1-PLACE OF DEATH Pronounced dead at City Hospital

City of BALTIMORE: (No. City Hospital St., 5-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

2-FULL NAME Emmitt Curtis

(a) RESIDENCE NO. 450 South Mt. St. Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Nebraska

PARENTS

10 NAME OF FATHER James Curtis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Nebraska

12 MAIDEN NAME OF MOTHER Mary Gossin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Nebraska

14 Informant Friend - Pockets

(Address)

15 Filed....., 19.....

MAY 26 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis
probably Rheumatic

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) James H Hutton, M. D.
(Coroner)

5-24, 1927 (Address) 7002 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State.....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart	5/26 1927
20 UNDERTAKER	**ADDRESS**
J. J. Daley Sons	1917 to 80

very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22586

CERTIFICATE OF DEATH.

E 22586

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Chapel ST.; 8-17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vera Peterson

(Residence in Baltimore: No. 1622 Chapel St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 5, 1927 (Month) (Day) (Year)

7-AGE, 20 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Peterson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. Md.

12-MAIDEN NAME OF MOTHER Grace Shiver

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Peterson

(Address) 1622 N. Chapel St

15- MAY 26 1927 HAMPSON JONES, M. D. 191....

Per ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 25, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1927 to May 25 1927 that I saw h[illegible] alive on May 25 1927 and that death occurred, on the date stated above, at 0230 P.M.

The CAUSE OF DEATH* was as follows:

Peri-Rectal abscess

(Secondary) Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. 1 ds.

(Signed) [illegible] M. D.

May 26, 1927 (Address) 600 N. Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery DATE OF BURIAL, May 26, 1927

20-UNDERTAKER George J Ruth ADDRESS 1735 Hartford Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22587 — CERTIFICATE OF DEATH. — 65-001 — E 22587

1-PLACE OF DEATH West Baltimore General Hospital — REGISTERED NO. 15-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~Bayonne~~ and Dukeland ST., WARD)

2-FULL NAME Vincent Russo

(a) RESIDENCE NO. 4202 Park Heights Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) WIFE of — HUSBAND of

6 DATE OF BIRTH (month, day, and year): May 24/1908

7 AGE: Years 19 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philip Rosso

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Theresa Rosso

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Philip Rosso

(Address) 4202 Park Heights Ave

15 Filed MAY 26 1927 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/19 1927 to 5/24 1927

that I last saw him alive on 5/24 1927

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. mos. 4 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 5/27 1927

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

CLAMPETT JONES, M. D. Registrar

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22588

E 22588

1-PLACE OF DEATH

REGISTERED NO. 91802

City of BALTIMORE: (No. 3900 Greenway St. 17-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meta Malchow.

(a) RESIDENCE NO. 3900 Greenway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Otto Malchow.

6 DATE OF BIRTH (month, day, and year): Jan. 30 1853

7 AGE: Years 74 Months 3 Days 25 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): New York.

PARENTS

10 NAME OF FATHER: Fredrick Humer

11 BIRTHPLACE OF FATHER (City or town)

(State or country): New York.

12 MAIDEN NAME OF MOTHER: Meta Humer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): New York.

14 Informant: Mrs. Grace Malchow

(Address): 3900 Greenway.

15 Filed ... 19... C. H. HUMPHRIES JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to May 25, 1927, that I last saw h[e] alive on May 24, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

& Cardiac Dilatation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Simms M. D.

5/26 1927 (Address) 4 202 Hanover Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery Date of Burial: May 27. 1927

20 UNDERTAKER: Henry J. Ruth ADDRESS: 1735 Harford ave.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22589

CERTIFICATE OF DEATH.

E 22589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 18-29 WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellick Burch. (Alexander Burch)

(a) RESIDENCE NO. 863 W Lombard ST. 21 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Katherine Burch.

6 DATE OF BIRTH (month, day, and year) Feb 4th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Button Drill Press

(b) General nature of industry, business, or establishment in which employed (or employer) Operator. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James E. Burch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Katherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25/27 19

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1927, to May 25, 1927, that I last saw him alive on May 25, 1927, and that death occurred, on the date stated above, at 6.15A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pneumococci Septicemia

(duration) yrs. mos 10 ds

CONTRIBUTORY (Secondary) Cardiac failure.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? NO Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood Culture

(Signed) E R Miller, M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Katherine Burch (Wife)

(Address) 863 W. Lombard St.

15 FILED 2-6 1927 C. HAMPSON JONES, M. D. Registrar

Per

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery.

DATE OF BURIAL May 28 1927

20 UNDERTAKER Lilly & Zeiler.

ADDRESS 1032 Mott St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22590

CERTIFICATE OF DEATH

129 ✓

E 22590

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3129 Dillon St., V L Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Streckfuss

(a) RESIDENCE NO. 3129 Dillon St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Geo J. Streckfuss

6 DATE OF BIRTH (month, day, and year) May 25 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	69	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER George Becker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Werner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Irene E. Steena.

(Address) 3129 Dillon St.

MAY 26 1927 19 C. HAMPSON JONES, M. D. Registrar

For R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15. 1926 to May 23 1927, that I last saw her alive on May 21 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Gangrene of both feet

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Brountas M. D.

5-24. 1927 (Address) 3037 Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

Date of Burial May 27 1927

20 UNDERTAKER Kelly & Zeier

ADDRESS 4008 Wash

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22591

CERTIFICATE OF DEATH

31 E 22591

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (3-5?) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Marlowe

(a) RESIDENCE NO. 3720 Elm ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)
1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hospital Records

(Address)

15 Filed MAY 26 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 19 27, to May 26, 19 27,

that I last saw her alive on May 26, 19 27,

and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W E Gallens M. D.

5-26-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bladensburg Md. Date of Burial May 29 19 27

20 UNDERTAKER F Gaxlis Son ADDRESS Bladensburg Md.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22592

CERTIFICATE OF DEATH.

90 E 22592

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1726 West Saratoga St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Randall

(a) RESIDENCE NO. 770 George St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Randall

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 48 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Common

(c) Name of employer: Mable to work 1 yr

9 BIRTHPLACE (city or town):

(State or country): Frederick Co

PARENTS

10 NAME OF FATHER: Wm Randall

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Frederick Co

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Frederick Co

14 Informant: Sarah Randall

(Address): 770 George St.

15 Filed 26 1927 C. HAMPTON JONES, M. D.

Per R.P. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Dilated Heart

(duration) yrs. mos. 2 ds.

(Signed) James M. Fenton M. D. (Coroner)

5-26 1927 (Address) 700 Cleveland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. State In the yrs. mos. ds.

Where was disease contracted, if not at place of death? 770 George St

Former or usual residence 770 George St

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: 5-26 1927

20 UNDERTAKER: Jos Lotta Gross — ADDRESS: 1402 Bd Ellamy

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22593

CERTIFICATE OF DEATH.

90

E 22593

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 121 W. Hamburg St. 23-31 Ward)

2-FULL NAME Irene Vanatteran

(a) RESIDENCE NO. 121 W. Hamburg St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Vanatteran

6 DATE OF BIRTH (month, day, and year): Aug 4th 1898

7 AGE: Years: 28 Months: 9 Days: 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore.

(State or country)

PARENTS

10 NAME OF FATHER: Horace Elkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Alexandria, Va

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Alex. Va.

14 Informant: Richard Vanatteran

(Address): 121 W Hamburg

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to May 24, 1927, that I last saw her alive on May 24, 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) 1 yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. J. Hamrock, M. D.

5/24, 1927 (Address) 801 Mary ne

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — Date of Burial: May 27

20 UNDERTAKER: Mrs. P. G. Elliott — ADDRESS: 1215 Ashland

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22594

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Ellicott ST. 11-7 WARD) 179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Carberry

(a) RESIDENCE No. 110 E. Centre St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie Carberry

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jennie Carberry

(Address) 110 E. Centre St

15 Filed 28 1927. 19 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 24 1927

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1927 to May 24, 1927, that I last saw him alive on May 24, 1927, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ch. Infiltrates.

Ascites

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Frank R. DiSanto, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 26, 27

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 42 25 Oakland

Spec. 1-10 21 M&T 1500 Blks.

E 22595 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22595

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321-Fifth av St. 17-24 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas E Raikes

(a) RESIDENCE NO. 1321-Fifth av St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Raikes

6 DATE OF BIRTH (month, day, and year) July 30-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
58	59	9	24	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer) So. Fireman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Perry Raikes

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary Jones (Address) 1321 Fifth Ave

15 Filed ..... 19 G. HAMPSON JONES, M. D. Registrar
6 1927 Per R.P.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/17, 1927, to 5/24, 1927.
that I last saw him alive on 5/24, 1927
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs 4 mos — ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Austin Goldsmith, M. D.

, 19 (Address) 836 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5, 28, 1927

20 UNDERTAKER Mrs G E O H Hooper & Co

ADDRESS 406

2C

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22596

100-001

CERTIFICATE OF DEATH.

E 22596

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 4-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Wiber

(a) RESIDENCE NO. 763 W. Lexington St. Ward

(Usual place of abode) ?

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER William Fisher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Ruda —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant [redacted] Records

(Address)

15 [illegible] 19

Per C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17

I HEREBY CERTIFY, That I attended deceased from February 18 1927, to May 25 1927, that I last saw h.. alive on May 25, 1927, and that death occurred, on the date stated above, at 3 50 p m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lenth M. D.

May 25 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — Mar. 27 1927

20 UNDERTAKER Wm Cook ADDRESS 932 E. Baltimore

Very Important. See Instructions on Back of Certificate.

6 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22597

CERTIFICATE OF DEATH.

90 E 22597

1-PLACE OF DEATH

City of BALTIMORE: (No. 302 E. Lafayette Ave St. 12-19 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E. Morgan

(a) RESIDENCE NO. 302 E. Lafayette Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George G. Morgan

6 DATE OF BIRTH (month, day, and year) March 29/1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Cecilton, Md

PARENTS

10 NAME OF FATHER Thomas P. Jones

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Cecilton, Md.

12 MAIDEN NAME OF MOTHER May E. Mace

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Cecilton, Md.

14 Informant George G. Morgan

(Address) 409 E. 28th St

15 Filed_____ 19____ Registrar

G. HAMPSON JONES, M. D.

Per_____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Failure

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senility

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Pallen M. D.

(Coroner)

5/26/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md Date of Burial May 27 1927

20 UNDERTAKER William Cook ADDRESS 502 E Pratt

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22598

22598

CERTIFICATE OF DEATH

REGISTERED NO. 74

1-PLACE OF DEATH Aged Mens Home

City of BALTIMORE: (No. 9 St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Gray

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	70	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Foreslal (Address) 1400 W Lexington St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927 to May 25, 1927

that I last saw him alive on May 25, 1927

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin C. Jones M. D.

(Address) 1115 E. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial May 27 1927

20 UNDERTAKER George J. Smith ADDRESS Hollins 1532

6

very important. See instructions on back of certificates.

Spec.—4-10-21—M&T—1500 Blks.

E 22599

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22599

CERTIFICATE OF DEATH.

X 131

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2237 Eutaw Place ST., 17-59 WARD)

2-FULL NAME Mrs. E. E. Betts. (Mrs. Malla)

(a) RESIDENCE NO. 15 Woodleigh Ave. ST., Asheville, N. C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred non-resident yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Curry L. Betts

6 DATE OF BIRTH (month, day, and year) Nov. 22-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	37	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anderson Co (State or country) South Carolina

PARENTS

10 NAME OF FATHER Wm M. Holliday

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Greenville Co S.C.

12 MAIDEN NAME OF MOTHER Emma L. Smith

13 BIRTHPLACE OF MOTHER (city or town) Greenville Co (State or country) S.C.

14 Informant Curry L. Betts (Address) 15 Woodleigh Ave Asheville N.C.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Date .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to May 25, 1927, that I last saw her alive on May 25, 1927, and that death occurred, on the date stated above, at 10 40 p. m.

The CAUSE OF DEATH* was as follows:

Pyomyohritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gynecological Exam.

(Signed) Robert E. Fricke, M. D.

19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N. C. — DATE OF BURIAL May 27-1927.

20 UNDERTAKER Charles J. Schwab. — ADDRESS 605 N. Monroe St.

Spec.—12-9-25—A Co.—200 Bks.

E 22600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. So Balto Gen Hospital St. 24-33 Ward)

2-FULL NAME Charles Monas Bauer

(a) RESIDENCE NO. Severn Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Bauer

6 DATE OF BIRTH (month, day, and year): [illegible] 1890

7 AGE: Years 37 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Garage operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Anne Arundel Co Md

(State or country)

10 NAME OF FATHER: Joseph Bauer

11 BIRTHPLACE OF FATHER (city or town): A A Co Md

(State or country)

12 MAIDEN NAME OF MOTHER: Victoria Geiter

13 BIRTHPLACE OF MOTHER (city or town): A A Co Md

(State or country)

PARENTS

14 Informant: Mr C. Thos Bauer

(Address) Severn Md

Filed [illegible] 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 26 May 1927

17 I HEREBY CERTIFY, That I attended deceased from 25 May, 1927, to 26 May, 1927, that I last saw him alive on 26 May, 1927, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Cause undetermined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 28, 1927 (Address) Severn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cemetery — Date of Burial: May 28/1927

20 UNDERTAKER: Wm J Tichnor's Sons — ADDRESS: Ft Pa Ave

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22601 +18 E 22601

E 22601

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at

City of BALTIMORE: (No._____ Pier No. 2 Pratt St. St., 4-6 Ward)

2-FULL NAME Charles M. Rogers.

(a) RESIDENCE NO. Ellicott City Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 10, 1888.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ellicott City Md.

PARENTS

10 NAME OF FATHER R. Dorsey Rogers.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary O. Martin.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Caleb D. Rogers. (brother)

(Address) Ellicott City Md.

15 [illegible] G. HAMPSON JONES, M. D.

Registrar

By ARR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing May 20, 1927 Found May 28, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

While riding in a Ford Coupe which ran over the dock into the water at Pier No. 2 Pratt St. Accidental Death.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Hall Leonard M. D.

(Coroner)

5/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State.....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Ellicott City Date of Burial May 31 1927

20 UNDERTAKER Scott M. Starr ADDRESS Ellicott City

Keep important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22602 × 90 E 22602

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 E ~~Fayette~~ Lexington ST., 18-26 WARD)

2-FULL NAME: Mary Monroe

(a) RESIDENCE NO. 1316 E Lexington ST., WARD Powhatan Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelius Monroe

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Powhatan Co Va.

PARENTS

10 NAME OF FATHER Chas. Jospn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Jasper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Saunders (Address) 1316 E ~~Fayette~~ Lexington St

15 Filed 6 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to May 24, 1927, that I last saw h alive on May 24, 1927, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernays Harris, M. D.

, 19 (Address) 38 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sec Va

DATE OF BURIAL May 26 1927

20 UNDERTAKER Robert T. Williams ADDRESS 1515 McElderry St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22603

CERTIFICATE OF DEATH

31 E 22603

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE NO. 532 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years 32 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1927, to 5 25, 1927, that I last saw her alive on 5 25, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Gibson Island

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank R. Lamville, M. D.

, 19 (Address) 1029 N Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

Date of Burial May 26 1927

20 UNDERTAKER Samuel Hensley

ADDRESS Baltimore

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22604 90 E 22604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1616 McCulloh ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy Ming

(a) RESIDENCE No. 1616 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1 — 1902

7 AGE: Years 25 Months Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper at

(b) General nature of industry, business, or establishment in which employed (or employer): Forging Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Percy Ming

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cordelia Landers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Percy Ming 1616 McCulloh

15 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to May 28—1927.

that I last saw him alive on May —, 19

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatism

Acute Bronchitis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A Cain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: May 27 1927

20 UNDERTAKER: Samuel T Hensley — ADDRESS: 678 N Bond

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22605

CERTIFICATE OF DEATH.

101-001 E 22605

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 2641 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Maring

(a) RESIDENCE NO. 128 Orchard Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Nov 17/1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Penna

PARENTS

10 NAME OF FATHER Earl Wilson Maring

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Carroll Co., Md.

12 MAIDEN NAME OF MOTHER Evelyn R. Willi[illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Earle W. Maring

(Address) 128 Orchard Ave

15 Filed MAY 27 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.R.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. ds.

(Signed) J. S. H. Pace M. D.

(Coroner)

5/27/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freedom Carroll Co Md Date of Burial May 28 19 27

20 UNDERTAKER Weaver Bros Inc ADDRESS Sykesville Md

Copy important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

William Reed

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22606

12-50/61-001 ✓

E 22606

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 325 - E - 25th St., 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Reed

(a) RESIDENCE NO. 325 - E - 25th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M | 4 Color or Race: Col | 5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1927

7 AGE: Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER William Reed

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Bush

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant G. Hamson Miller-Reed

(Address) 325 - E. 25th St

Filed MAY 27 1927 G. HAMPSON JONES, Registrar

For C&K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1927 to May 26, 1927, that I last saw h[illegible] alive on May 26, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis C. Johnson, M. D.

, 19 (Address) 2329 - E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakley Cemetery — Date of Burial: May 27 1927

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 325 - Oakland

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 E 22607

E 22607

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 Orleans St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Anderson

(a) RESIDENCE NO. 1309 Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Anderson

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE: 27 Years 26 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): N. C.

(State or country)

PARENTS

10 NAME OF FATHER: unk

11 BIRTHPLACE OF FATHER (City or town): unk

(State or country)

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town): unk

(State or country)

14 Informant: Rosa Anderson

(Address) 1309 Orleans St

Filed 5-27-1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1927, to May 22, 1927, that I last saw him alive on May, 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Dilation

Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) _____, M. D.

May 25 1927 (Address) 508 Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: May 27 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 631 Orleans St

Key Important: See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22608

E 22608

CERTIFICATE OF DEATH

REGISTERED NO. 72

1-PLACE OF DEATH

City of BALTIMORE: (No. 1203 N. Gay St. St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucia Messina

(a) RESIDENCE NO. 1203 N. Gay St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Petrio Messina

6 DATE OF BIRTH (month, day, and year): Jan 21 1863

7 AGE: Years 64 Months 4 Days 5 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: John Catoana

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Elizabeth Messina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Frank DeAntonio

(Address) 1203 N. Gay St

15 Filed MAY 27 1927 C. HAMPSON JONES, M. D. Registrar Per R.J.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1926 to May 26, 1927

that I last saw h alive on May 25, 1927

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Lesion Aortic

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gardner L. Altabista M. D.

5-26. 1927 (Address) 1058 N Broadway

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery Date of Burial: May 28 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1736 Hoffman Ave.

Key important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Satterfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 22609

E 22609

CERTIFICATE OF DEATH

1-PLACE OF DEATH Md. Gen. Hosp. 9-18 REGISTERED NO.

City of BALTIMORE: (No. 1603 Holbrook St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard O. Slatterfield

(a) RESIDENCE NO. 1603 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 11 1904

7 AGE Years: 22 Months: 8 Days: 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: Howard Slatterfield

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Emma Mosenthal

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balt.

14 Informant (Address): Mrs. Slatterfield 1603 Holbrook st.

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per

5 27 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1927 to May 24th 1927

that I last saw h[illegible] alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Fall off of [illegible]

(duration) 1 yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. Date of Burial: May 28 1927

20 UNDERTAKER: George J. Frost ADDRESS: 1735 Hanford Av.

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dueno ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

CERTIFICATE OF DEATH

E 22610

E 22610 PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE, (No. ..... ST., 1419 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Dueno

(a) RESIDENCE NO. 12 S. Carey St ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Dr Dueno

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS
10 NAME OF FATHER: Unknown.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Julia Dueno 12 S Carey St

15 Filed MAY 27 1927 19 L. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to May 24, 1927, that I last saw h[illegible] alive on May 24, 1927, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Secondary anemia
Cause undetermined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Blood Picture

What test confirmed diagnosis?

(Signed) W Wallace Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem — DATE OF BURIAL: 5-28 1927

20 UNDERTAKER: Mrs Chas A Kohler — ADDRESS: 60 Wilkins Ave

Spec, -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22611

CERTIFICATE OF DEATH

89 E 22611

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2518 N Mosher St. 16-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Meusel

(a) RESIDENCE NO. 2518 N Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 49 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Meusel

6 DATE OF BIRTH (month, day, and year) Sept 8th 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	49	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Calvert Carpet Cleaning Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Cornelius Meusel

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Caroline Meusel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary E Meusel

(Address) 2518 N. Mosher St

15 Filed ..... 19 ..... Registrar.

MAY 27 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 29th 1927 to May 25th 1927.

that I last saw him alive on May 24 1927.

and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Heart undetermined

(duration) Long yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — Date of Burial: 5-28 1927

20 UNDERTAKER: Mrs Chas A G Rohde — ADDRESS: 1100 Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22612

CERTIFICATE OF DEATH.

18 E 22612

1-PLACE OF DEATH Found in a Ford Coupe in the water at

REGISTERED NO.

City of BALTIMORE: (No. Pier No.2 Pratt St. St., 12-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elias C. Stump.

(a) RESIDENCE NO. 2118 N. Calvert St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

6a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXX Verma Stump.

6 DATE OF BIRTH (month, day, and year) June 19, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Charles Stump.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Verma Stump. (wife)

(Address) 2118 N. Calvert St.

Filed [illegible] 19 C. HAMPSON JONES, M. D.

27 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing May 20, 1927 Found May 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

While driving a Ford Coupe which ran over the dock into the water at Pier 2 Pratt St. Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Leonhardt, M. D. (Coroner)

5/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del

Date of Burial May 27-27

20 UNDERTAKER Wm J Lawler Son

ADDRESS N. Pa. Ave

Cor.—1-12-23—M&T—100 Bks.

E 22613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 22613

1-PLACE OF DEATH

REGISTERED NO. 1927-20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 532 W. Baltimore ST. 13 WARD)

2-FULL NAME Benjamin F. Phillips.

(a) RESIDENCE No. 532 W. Baltimore ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Phillips

6b DATE OF BIRTH (month, day, and year): July 15 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	10	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): London Co. Va.

10 NAME OF FATHER: John Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Exley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

PARENTS

14 Informant: Sophia Phillips
(Address): 532 W. Baltimore

15 Filed ... 192 Per ... Registrar

C. HAMPTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Disease
Heart
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) ... M. D.
(Coroner)
5/25, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 27 1927

20 UNDERTAKER: Geo. W. Little — ADDRESS 2740 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

E 22614

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22614

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. W-30 Ward)

2-FULL NAME Elizabeth Laumann

(a) RESIDENCE NO. Fullerton Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Laumann

6 DATE OF BIRTH (month, day, and year) Oct 17th 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Meeth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Tribe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Charles L. Laumann

(Address) Fullerton Md.

15 Filed..... 19..... C. RAMPON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall

Rupture of intestines (duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Gen Peritonitis

(duration) ... yrs. ... mos. ... ds.

May 27 (Signed) Geo Edwin Pohl M. D. (Coroner)

27, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: May 28 1927

20 UNDERTAKER: Frederick Lauraine — ADDRESS: Fullerton

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22615

CERTIFICATE OF DEATH.

90 E 22615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 1 Ward)

2-FULL NAME Mrs Lily Shaw

(a) RESIDENCE NO. 1902 Warwick Ave 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earl Shaw

6 DATE OF BIRTH (month, day, and year) April 15-1872

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
55	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Frank Shaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Frank Shaw

(Address) 2500 W. Fayette St

Filed MAY 27 1927 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 21 1927 to May 25 1927, that I last saw her alive on May 25 1927, and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH was as follows:

Chronic Valvular Cardiac Disease (mitral insufficiency and stenosis)

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon X. Norwood M. D.

May 25 1927 (Address) Church Home & Infirmary

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial May 28th 1927

20 UNDERTAKER J. B. Pippert ADDRESS 1850 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22616

CERTIFICATE OF DEATH.

169 E 22616

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Pier No.4 Pratt St. St., 5-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H.Klare.

(a) RESIDENCE NO. 100 N.Front St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Divorsed.

5a If ~~MARRIED, WIDOWED~~ HUSBAND OF ~~WIFE OF~~ ~~XXXXXXXX~~ d. or divorced Mary Klare.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) St.Louis Mo.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant William H.Klare Jr.(son)

(Address) 1718 Warwick Ave.

15 Filed_____, 19_____

C. HAMPSON JONES, M. D.

Per_____ Registrar

MAY 27 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M Reinhardt M. D. (Coroner)

5/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial May 30 27

20 UNDERTAKER Wendell J Hoppel ADDRESS 3015 E Eden St

Spec.—1-12-23—M&T—500 Blks.

E 22617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22617

CERTIFICATE OF DEATH.

46

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 W. Lanvale ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Theophile Ridgely

(a) RESIDENCE NO. 248 W. Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ridgely

6 DATE OF BIRTH (month, day, and year) Dec 8 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
63.	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Theophil

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant John T. Ridgely (Address) 248 W. Lanvale St.

15 [illegible] 27 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12 1927 to May 24 1927, that I last saw h alive on May 24 1927, and that death occurred, on the date stated above, at 5 A M

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

mths (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri

mths (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. B. Cromlish M. D.

, 19 (Address) 249 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem DATE OF BURIAL May 27 1927

20 UNDERTAKER Henry H. Tenkins Sons ADDRESS Mt. Calvert & Cathedral

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22618

90E 22618

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables - ST. 1352 WARD)

2-FULL NAME Mrs. Sarah G. Chew -

(a) RESIDENCE NO. Home for Incurables - ST., Hoth St. WARD 4 Cedar Ave. Balto
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Widow of -

6 DATE OF BIRTH (month, day, and year) July 20. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	86	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne's Co Maryland

PARENTS

10 NAME OF FATHER Henry Hollyday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co - Md

12 MAIDEN NAME OF MOTHER Annamaria Hollyday

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co - Maryland

14 Informant Frank Chew Wash.
(Address) 329 Homes Bldg. DC

15 Filed MAY 27 1927 C. HAMPSON JONES, Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to May 25, 1927, that I last saw her alive on May 25, 1927, and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W. W. Mayo, M. D.

5/26/1927 (Address) Baltimore - Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 28 1927

20 UNDERTAKER D. [illegible] ADDRESS

John Armistead & Sons 1900 Eutaw Place

Spec.—1-10-21 M&T 1500 Bks.

E 22619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 22619

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1532 Linden Ave (St.) (14-20) (Ward)

2-FULL NAME Clara A. Norris

(a) RESIDENCE No. 1532 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert H Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Katherine A Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Robert H Powell

(Address) Harwood apts

15 Filed MAY 27 1927, 19 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 19 27

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 25, 1927, that I last saw h[illegible] alive on May 25, 1927, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McIlvoy, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Chapel M.P. Cem Harford Co	May 29/27.
20 UNDERTAKER and	ADDRESS
Paul O. Mitchell Sons.	1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 22620

E 22620 1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3908 Park Heights Ave. St. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Henry Laker

(a) RESIDENCE NO. 3908 Park Heights Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret D. Laker

6 DATE OF BIRTH (month, day, and year) April 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hauling

(b) General nature of industry, business, or establishment in which employed (or employer) ofb

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William H. Laker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Lena (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Margaret D. Laker

(Address) 3908 Park Heights Avenue

15 Filed MAY 27 1927 Per C. HAMPSON SOMS, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927. to May 26, 1927.

that I last saw him alive on ....., 19....,

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Benardo Lorr M. D.

5-26-27 (Address) 914 East Biddle Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL D. New Cathedral Cemetery — DATE OF BURIAL May 30 1927

20 UNDERTAKER Joseph L. Cook — ADDRESS 1003 Madison St

Spec.—1-12.22—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22621

CERTIFICATE OF DEATH

E 22621

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Rayner and Dukeland ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hill

(a) RESIDENCE NO. 912 Franklin Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hill

7 DATE OF BIRTH (month, day, and year): Feb. 9, 1876

8 AGE: Years 51; Months 3; Days 16; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Baltimore City

10 BIRTHPLACE (City or town) (State or country): Baltimore, Maryland

10 NAME OF FATHER: Thomas J. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond, Virginia

12 MAIDEN NAME OF MOTHER: Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond, Virginia

14 Informant: Mrs. Annie Hill

(Address) 912 Franklin Road

15 Filed 2 7 1927 19

C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/18 1927 to 5/25 1927

that I last saw him alive on 5/25/ 1927

and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary): acute uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

19 (Address) W. 13-9-18.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 28 1927

UNDERTAKER: Edgar B. Cook

ADDRESS: 1003 W. Saratoga St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22622

E 22622

CERTIFICATE OF DEATH.

186-004

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel C. Schnidt

(a) RESIDENCE NO. 718 S. Port St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXX

6 DATE OF BIRTH (month, day, and year) Feb 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Schnidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Trautfelder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Charles Schnidt

(Address) 718 S. Port St

15 Filed 5 27 1927 C. HAMPSON JONES, M. D.

Per R H Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 May 26/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia due to bilateral Otitis Media & extensive Eczema

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J H Prince, M. D.

(Coroner)

5/27/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial May 29 1927

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS 1710 Fleet St.

Spec-12-23-21—E.B.R.S.—400 Bks.

E 22623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

E 22623

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 McCulloh St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Armstrong

(a) Residence No. 918 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-12-27

7-AGE. ....yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Leon Inlose

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Sarah Armstrong

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country),

14-

(Informant)

(Address)

15-

Filed JUN 27 1927 19..

C. HAMILTON JONES, M. D.
Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-16-27

17- I HEREBY CERTIFY, That I attended deceased from 5-12-, 1927 to 5-16-, 1927

that I last saw h[illegible] alive on 5-16 1927

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Maternal Syphilis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Esta F. Dodge M. D.

, 19 (Address) University Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.

DATE OF BURIAL. ....., 19..

20-UNDERTAKER.

ADDRESS

UNIVERSITY OF MARYLAND

E 22624 Spec. 200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 22624

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1104 Woodyear St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Veney

(a) RESIDENCE NO. 1104 Woodyear St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alberta Veney

6 DATE OF BIRTH (month, day, and year): Oct 22- 64

7 AGE: Years 62 Months 7 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): O & S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Veney

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Alberta Veney

(Address): 1104 Woodyear

15 Filed 5-27-1927 19 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 24 1927

that I last saw him alive on May 24 1927

and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B N Hatcher M. D.

5/26, 1927 (Address) 1775 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Date of Burial: May 27 1927

20 UNDERTAKER: Wm H Chase & Son ADDRESS: 1400 Mark

Spec.—12-9-25—A Co.—200 Blks.

248

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 0 2 E 22625
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL. 16-23

38 E 22625
REGISTERED NO.

City of BALTIMORE: (No. 1 St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Johnson

(a) RESIDENCE NO. 100 Riggs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-16-26

7 AGE — Years: ~~10 mos.~~ | Months: 11 | Days: 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) W. Va

12 MAIDEN NAME OF MOTHER Marie Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed 5-27 1927, 19
Per [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 19 1927, to May 25 1927, that I last saw her alive on May 25, 19 27, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Syphilis (duration) yrs. 1 0 mos. ds.

18 Where was disease contracted if not at place of death? Congenital syphilis

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

5-26-27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Grace — Date of Burial: May 27, 27

20 UNDERTAKER: Sam W Crase & Son — ADDRESS: 1400 Mosher

Spec.-7-17-26—A Co.—200 Bks.

22626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 22626

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Jones

(a) RESIDENCE NO. No address St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) District of Columbia

PARENTS

10 NAME OF FATHER Wm. Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Price

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

7 1927 1405

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 14, 19 27, to May 25, 19 27,

that I last saw her alive on May 25, 19 27,

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gallaher, M. D.

5-26-27 19 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Breeze Date of Burial May 29, 19 27

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health, MAY 27 1927

A Jones 111 S Eden St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22627 E 22627

22627

CERTIFICATE OF DEATH.

10-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 217 N. Curley ST., 6-11 (WARD)

2-FULL NAME Ruth M. McCarver

(a) RESIDENCE NO. 217 N. Curley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 20-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank E. McCarver

11 BIRTHPLACE OF FATHER (city or town) Charlotte. (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary E. Meck

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mary E. McCarver
(Address) 217 N. Curley St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1927 ROH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25-27 to May 27 1927, that I last saw her alive on May 27 1927 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) 1 mos ds.

CONTRIBUTORY (Secondary) Toxic Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Hurman M.D.

May 27 27 (Address) 2138 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL May 28 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22628

REGISTERED NO. E 22628

1-PLACE OF DEATH

City of BALTIMORE: (No. 1927 E Monument St., 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Gantz

(a) RESIDENCE NO. 1927 E. Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Magdalena Gantz

6 DATE OF BIRTH (month, day and year) March 10/1860

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	77	2	16	25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Iron 084

(b) General nature of industry, business, or establishment in which employed (or employer) Metalworker

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Fred Gantz

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Given

14 Informant George F. Gantz

(Address) 1927 E Monument St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to May 22a, 1927, that I last saw h.. alive on May 22, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos 3 2 ds.

CONTRIBUTORY (Secondary)

Contusion (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 1927 E Monument St

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 5/27 John Aza, M. D.

5/27 1927 (Address) 1937 E Monument St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. L. Cannel — Date of Burial May 28 1927

20 UNDERTAKER Leo M. Friedman — ADDRESS 511 N. Howard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22629

E 22629

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Towson St. 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kerrigan

(a) RESIDENCE No. 1416 Towson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin J. Kerrigan

6 DATE OF BIRTH (month, day, and year) March 15 1863

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	64	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Lambros O'Donnell

(Address) 1416 Towson St.

15 5 7 1927 C. HAMPSON JONES, M. D. Registrar

Pct

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 25. 1927.

17 I HEREBY CERTIFY, That I attended deceased from 11. 1. 26. 1926, to 5. 25. 1927.

that I last saw her alive on 5. 25. 1927

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Generalized atheroscle-
rosis

Diabetes mellitus

(duration) Over 1 Year mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene both feet (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) J. Edward Norris, M. D.

5. 26. 1927 (Address) 107 East West

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 28 1927

20 UNDERTAKER Margaret A. Flynn — ADDRESS 1412 Linden Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 22630

CERTIFICATE OF DEATH.

129 E 22630

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 120 Schenley Rd. ST., 27-53 WARD)

2-FULL NAME Mary Gildenfenney

(a) RESIDENCE NO. 120 Schenley Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed -

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Chas. J. Gildenfenney

6 DATE OF BIRTH (month, day, and year) March 17 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	2.	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George B. Gildenfenney

(Address) 120 Schenley Road.

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from October 25, 1926, to May 25, 1927, that I last saw her alive on May 25, 1927 and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Arteri-Sclerosis -

(duration) 7 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis? Lab + Clinical

(Signed) John S. Fahey, M. D.

5/31, 1927 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL May 28 1927

UNDERTAKER Liston P. Fassett ADDRESS 2628 St Paul

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22631

CERTIFICATE OF DEATH.

74-0 E 22631

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 W. Lafayette Ave., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Jones

(a) RESIDENCE NO. 1122 W. Lafayette Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE: Years 49 Months 0 Days 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town)..... (State or country) Va.

PARENTS

10 NAME OF FATHER Chas. Miller

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Va

12 MAIDEN NAME OF MOTHER Hall

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country)

14 Informant Mr. Alfred Jones (Address) 1122 W. Lafayette Ave

15 Filed May 28, 1927 Per C. HAMPSON JONES, M. D. Registrar R R H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBITORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. C. Hemsley, M. D. (Coroner)

May 26, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nelson Va Date of Burial May 28 1927

20 UNDERTAKER Samuel J. Hemsley ADDRESS 1122 W. Lafayette Ave

Spec.—1-12-23—M&T—500 Blks.

22632

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 E 22632

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto. General Hospital

CITY OF BALTIMORE: (No.) Payne and Dukeland ST. 14 10 WARD)

2-FULL NAME Lydia Robinson

(a) RESIDENCE NO. 2019 Etting ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of: Chas F. Robinson

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Essex Co. Va

10 NAME OF FATHER: Minters Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lydia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Della Robinson

(Address): 2019 Etting St

15 Filed 7 1927

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/22, 1927, to 5/26, 1927, that I last saw her alive on 5/26, 1927 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary): Acute uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: May 30 1927

20 UNDERTAKER: Edward L. Hensley ADDRESS 578 Baltimore St

Spec.—1-12-23—M&T—500 Bks.

E 22633

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-E 22633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Hammond

(a) RESIDENCE No. 1622 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lloyd N. Hammond

6 DATE OF BIRTH (month, day, and year): 1848

7 AGE: Years 79; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Samuel Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Caroline Dotson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Gertrude Braxton

(Address) 1324 Druid Hill Ave

15 Filed 7 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1927

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 24, 1927, that I last saw h[illegible] alive on May 24, 1927, and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. L. Shelton, M. D

5/26, 1927 (Address) 1200 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview Md

DATE OF BURIAL: May 28 1927

20 UNDERTAKER: Edward Kemsley

ADDRESS: Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22634 ✓ 48 E 22634

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1825 Bell St — St. 24-31 Ward)

2-FULL NAME Ella D. LeBlanc

(a) RESIDENCE NO. 1825 Bell St — St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Robt. LeBlanc

6 DATE OF BIRTH (month, day, and year): Apl 28 - 1859

7 AGE: Years 68; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Richmond

(State or country): Va

PARENTS

10 NAME OF FATHER: John Acree

11 BIRTHPLACE OF FATHER (city or town):

(State or country): England

12 MAIDEN NAME OF MOTHER: Margaret E Radford

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Mrs Margaret Link

(Address): 1825 Bell St

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 26, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to May 26, 1927, that I last saw h[illegible] alive on May 25, 1927, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma involving bones on left side of face

(duration) don't know yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Toms, M. D.

(Address) 107 East West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakwood Cem. Richmond Va. Date of Burial: 5/29/1927

20 UNDERTAKER: John F Howard & Son. ADDRESS: 902 Holland St

Spec.—1-12-23—M&T—500 Blks.

E 22635

HEALTH DEPARTMENT—CITY OF BALTIMORE E 22635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 N. Carey (St.) 16-23 (Ward) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Ball

(a) RESIDENCE NO. 1018 N. Carey ST., WARD Fathers Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Ball

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Bradley

(Address) 1018 N. Carey St

15 Filed MAY 27 1927 C. HAMPSON JONES, M. D. Registrar

By RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 24, 1927.

that I last saw h live on May 24, 1927

and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) about 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Ralph [illegible] M.D.

(Address) 1534 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lothair Charles Co Md — DATE OF BURIAL May 28, 27

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

Spec. -7-17-26—A Co.—200 Bks.

E 22636

HEALTH DEPARTMENT—CITY OF BALTIMORE

3001

+ 101

E 22636

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No. Calvert 33rd St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sidney H. Street

(a) RESIDENCE NO. Monkton, Md. St. Ward

(Usual place of abode) Monkton, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Chas. H Street

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hutchins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Deceased. (Address)

1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927 to May 27, 1927

that I last saw him alive on May 27, 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcemia

Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Geraghty M. D.

. 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Co. Md St James

Date of Burial May 31 1927

20 UNDERTAKER Wm E Brooks

ADDRESS Sparks Md

Spec.–7-17-26—A Co.—200 Bks.

Heller Wash. Gough

HEALTH DEPARTMENT—CITY OF BALTIMORE

22637

CERTIFICATE OF DEATH

129 E 22637

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 133 N. Duncan St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Gardester

(a) RESIDENCE NO. 133 N. Duncan St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 1 female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Gardester

6 DATE OF BIRTH (month, day, and year): July 29 1843

7 AGE — Years: 83 Months: 9 Days: 27 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Washington D. C.

(State or country)

PARENTS

10 NAME OF FATHER: John Pickering

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth King

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Elizabeth Gardner

(Address) 126 West University Parkway

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 5, 19 27, to May 26, 19 27, that I last saw her alive on May 25, 19 27, and that death occurred, on the data stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) " " "

(duration) " yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Keller, M. D.

5/27, 19 27 (Address) 1937 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: 5/28 1927

20 UNDERTAKER: William Cook — ADDRESS: 532 E. North

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22638

CERTIFICATE OF DEATH.

E 22638

63

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1627 Lamsdale ST. 17-51 WARD)

2-FULL NAME Barlington Thomas Brown

(a) RESIDENCE NO. 2627 Lamsdale St., 12 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie L Brown

6 DATE OF BIRTH (month, day, and year) March 28 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonecutter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Randallstown Md

PARENTS

10 NAME OF FATHER Enoch Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Martha Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Kent Brown
(Address) 1803 Bernard St.

15 Filed ....., 19 .... Registrar
Bur RR19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to May 27, 1927.

that I last saw him alive on May 26, 1927.

and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Addisons disease

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe R. Knox M. D.

May 27 1927 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL May 30 1927

20 UNDERTAKER William Cook ADDRESS 502 E Baltimore

G. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22639 E 22639

CERTIFICATE OF DEATH.

154-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1051 N. Bay ST., 7-13 (WARD)

2-FULL NAME Marian Baker.

(a) RESIDENCE NO. 1051 N. Bay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md

PARENTS

10 NAME OF FATHER Chas Baker.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mable Teager

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mable Teager.
(Address) 1051 N Bay St

15 Filed ....., 19.... Registrar

8 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 27, 1927, that I last saw him alive on May 27, 1927, and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale.

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 27, 1927 (Address) 1058 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 28 1927
20 UNDERTAKER	ADDRESS
W. H. Cook	502 E Northern

Spec.—1-12-23—M&T—500 Bks.

22640

HEALTH DEPARTMENT—CITY OF BALTIMORE

1591 1927 E 22640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N. Bay ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Baker.

(a) RESIDENCE NO. 1031 N. Bay St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 8/1927

7 AGE — Years — Months — Days: 19 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas Baker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mable Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mable Baker

(Address) 1031 N Bruning

15 Filed ..... 19 ..... Registrar

HAMPSON-JONES M F

8 1927 Pa

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 27, 1927, that I last saw h— alive on May 20, 1927 and that death occurred, on the date stated above, at 2 A m

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: May 28 1927

20 UNDERTAKER: Wilson Cook — ADDRESS: 502 E Madison

Spec.—1-12-23—M&T—500 Blks.

E 22641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22641

CERTIFICATE OF DEATH.

100 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 627 (ST.) Jasper (WARD) 17-25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Adams

(a) RESIDENCE NO. 627 (Usual place of abode) ST., Jasper WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

7 DATE OF BIRTH (month, day, and year): Unknown 1865

8 AGE — Years: 62 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: —

10 BIRTHPLACE (city or town) (State or country): VA

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Nannie Rich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): VA.

14 Informant: John Medley

(Address): 627 Jasper St.

15 Filed 8 1927, 19 — C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to May 23, 1927, that I last saw h[illegible] alive on May 24, 1927 and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia,

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Congestion of the Liver (duration) 0 yrs. 0 mos. 24 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Altamburg, M. D.

, 19 (Address) 1037 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemt	5/28/27
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1225 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22642

18 E 22642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating in the water at

City of BALTIMORE: (No.) Pier No.2 Pratt St. St., 17-24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hemsley.(C)

(a) RESIDENCE NO. 537 Dolphin St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) C+O

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Annapolis, Md.

PARENTS

10 NAME OF FATHER William Hemsley.C.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Annapolis, Md.

12 MAIDEN NAME OF MOTHER Lucinda Kahn(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annapolis, Md.

14 Informant Hattie Campbell.(C) niece.

(Address) 537 Dolphin St.

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per L.P.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing May 15 1927 Found May 21, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Fell fro a wharf.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Steinhardt, M. D.
(Coroner)

5/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: May 28, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS: 322 W Schroeder St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22643 | CERTIFICATE OF DEATH. | 31 E 22643

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 729 N Collington St., 7-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Zelenka

(a) RESIDENCE NO. 729 N Collington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 17 1909

7 AGE: Years 17 | Months 11 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Baltimore

PARENTS

10 NAME OF FATHER: Matthew Zelenka

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Antonia Matejka

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Bohemia

14 Informant: Matthew Zelenka

(Address) 729 N. Collington Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 May 26

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26 1927, to May 26, 1927, that I last saw h[illegible] alive on May 26, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

May 27 (Address) 804 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial May 30 1927

20 UNDERTAKER: Frank Crockett ADDRESS 1906 Eastlavde

pec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22644

1001

E 22644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO. 1014

CITY OF BALTIMORE: (No. Caroline ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs James Gordon.

(a) RESIDENCE NO. 1015 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of widowed

DATE OF BIRTH (month, day, and year) June 9, 1849

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	37	11	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Chas B. Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Mrs. Gordon

(Address) 1015 Fremont Ave

Filed 6 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/27

17 I HEREBY CERTIFY, That I attended deceased from 5/24/27, 1927 to 5/27/27, 1927 that I last saw h[illegible]live on 5/27/27, 1927 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Ruptured gastric ulcer

(duration) yrs. mos 3 ds

CONTRIBUTORY (Secondary) Colon (Fremont)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5/24/27

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Hamilton M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 30 1927

20 UNDERTAKER Rita Wakefield — ADDRESS 914 Fremont Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22645

CERTIFICATE OF DEATH

90

E 22645

1-PLACE OF DEATH Aged Womens Home REGISTERED NO. 14-27

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emily S. Greenfield

(a) RESIDENCE NO Lexington & Calhoun St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 12 1837

7 AGE: Years 90 Months 2 Days 18 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John F Drepel

11 BIRTHPLACE OF FATHER (City or town) ____
(State or country) Germany

12 MAIDEN NAME OF MOTHER Henretta Brent

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Germany

14 Informant Ella Z Jones
(Address) 1400 W Lexington

8 1927 C. HAMPSON JONES, M. D.
15 Filed ____ Registrar
Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to May 28, 1927
that I last saw h alive on May 27, 1927
and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Artio-sclerosis
Hypertension
(duration) 3 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) Edwin B. Jones M. D.
, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — Date of Burial May 30 1927

20 UNDERTAKER George J Smith — ADDRESS 153 Hollins

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22646

CERTIFICATE OF DEATH.

10 1-001 E 22646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 Linden Ave ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel C. Smith—

(a) RESIDENCE NO. 839 Linden Ave ST. — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 19, 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 0'10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Smith—

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Amelia F. Broom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Emma B. Stall

(Address) 839 Linden Ave

15 Filed 8 1927 19 C. HAMPSON JONES, M. D. Per R L P Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927 ... to May 25. 1927, that I last saw him alive on May 25. 1927, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chew, M. D.

5/27, 1927 (Address) 924 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL May 29 1927

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Eutaw St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22647

CERTIFICATE OF DEATH.

E 22647

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Hotel Belvidere. St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Walker.

(a) RESIDENCE NO. 1014 Bishop Rf. Detroit, Mich. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred En route. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Divorced.

5a If ~~married, widowed~~ or divorced HUSBAND of ~~XXXXXXXX~~ Edith T. Walker

6 DATE OF BIRTH (month, day, and year) Septmber 2° 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	8	25	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Pre. Walker Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Adv. Distributers.

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Michigan.

PARENTS

10 NAME OF FATHER Henry W. Walker.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Michigan.

12 MAIDEN NAME OF MOTHER Eva.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Michigan.

14 Informant William T Walker. (son)

(Address) 1014 Bishop Rd. Detroit. Mich.

15 1927 G. HAMPSON JONES, M. D.

16 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

5/28 1927 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Detroit-Mactuan Date of Burial 5-30-27.

20 UNDERTAKER Martin Funeral Home ADDRESS 5 Fort Ave.

Witness: W. W. Kirchhoff Via Penna R.R.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22648

CERTIFICATE OF DEATH

90 E 22648

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 223 N High St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Grossi

(a) RESIDENCE NO. 223 N High St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angelo Grossi

6 DATE OF BIRTH (month, day, and year) 12/25 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	82	5	2 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Verdun France

(State or country)

PARENTS

10 NAME OF FATHER Martin Nettie

11 BIRTHPLACE OF FATHER (City or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Martinnette

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant Mrs Ida Lissile

(Address) 223 N High St

15 Filed 5 29 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14 1927 to May 26 1927

that I last saw h[illegible] alive on May 26 1927

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows: Myocardial failure

Arterio-sclerosis, etc.

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 8 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Street, M. D.

, 19 (Address) 5112 Walbrook Ave Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial 5/30 1927

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

E 22649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22649

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged HOme ST. 5-8 WARD)

2-FULL NAME Samuel . H . SOlmannovitz

(a) RESIDENCE NO. 115 Aisquith St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Solmannovitz

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unkown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs F Goldman (Address) 3451 Cottage Ave

15 Filed 5 29 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 19 27

17

I HEREBY CERTIFY, That I attended deceased from March, 1927, to May 27th, 1927,

that I last saw her alive on , 19 27,

and that death occurred, on the date stated above, at 130 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Lehmann, M. D.

5th, 1927 (Address) 308 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem

DATE OF BURIAL 5 29 27 19

20 UNDERTAKER Jack Lewis. 1439 E Baltimore St

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22650

CERTIFICATE OF DEATH.

46 E 22650

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 134 S Highland Ave (Ward) 10

2-FULL NAME Margaret Crosby

(a) RESIDENCE NO. 134 S Highland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles D. S. Crosby

6 DATE OF BIRTH (month, day, and year): Feb 28 1881

7 AGE: Years 46 | Months 2 | Days 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Albert H. Leinkuhler

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER: Lena Rattman

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Margaret Wentz

(Address) 134 N. Duncan St

15 Filed ....., 19 ..... J. HAMPSON JONES, M. D., Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7 1927, to May 26, 1927, that I last saw h.... alive on May 25, 1927, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

Generalized Carcinomatosis

Secondary Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Leitch M. D.

, 19 (Address) 156 N. Mitchell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery Date of Burial May 29 1927

20 UNDERTAKER: Wm C. Miller & Son ADDRESS 2334 Jefferson

9 1927

Spec.—1-10-21—M&T—1500 Bks.

E 22651 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 22651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1316 N. Stricker ST. 15-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emeline R. Huttington

(a) RESIDENCE NO. 1316 N. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Huttington

6 DATE OF BIRTH (month, day, and year) Mch 14-1851

7 AGE 76 Years 75 Months 7 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lloyd Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Hooden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Jas. M. Huttington 1316 N. Stricker

15 Filed MAY 29 1927 By HAMPSON JAMES, M. D. Registrar Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1927 to May 26 1927 that I last saw h alive on May 26 1927 and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. L. Shelton, M. D.

(Address) 1316 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. Grove DATE OF BURIAL May 29 1927

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1402 Madison

pec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22652

CERTIFICATE OF DEATH.

16-002

E 22652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) 21-24 (Ward)

2-FULL NAME Emma Sauerhoff

(a) RESIDENCE NO. 766 Mc Henry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	infant

6 If married, widowed, or divorced HUSBAND of or) WIFE of infant

DATE OF BIRTH (month, day, and year) Nov. 14, 1926

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	14	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant (all)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Elmer Sauerhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elsa Hecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant father Mr. Sauerhoff.
(Address) 766 Mc Henry St.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar
By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927 to May 28, 1927.

that I last saw her alive on May 28, 1927

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Dysentery + malnutrition.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Elizabeth Sherman, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL 5/30/1927

20 UNDERTAKER John J. Bowman & Son

ADDRESS 701 Howard St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22653 · CERTIFICATE OF DEATH. 129 E 22653

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1630 W. Lanvale St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Banks

(a) RESIDENCE NO. 1630 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Amos W. Banks

(Address): 1630 W Lanvale St

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

NOV 29 1927 RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/26/1927.

17 I HEREBY CERTIFY, That I attended deceased from 4/30/1927, to 5/26/1927, that I last saw him alive on 5/25/1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hawkins, M. D.

5/27/1927 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem — May 27 1927

20 UNDERTAKER — ADDRESS

Daniel Easton — 916 Pa ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22654
1-PLACE OF DEATH

90 E 22654
REGISTERED NO.

City of BALTIMORE: (No. 572 Ireland St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Boslow

(a) RESIDENCE NO. 572 Ireland St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Widower Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Boslow

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster 53
(b) General nature of industry, business, or establishment in which employed (or employer) Express
(c) Name of employer General.

9 BIRTHPLACE (city or town).....
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Moses Boslow

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Rosie Dy

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Va

14 Informant Ely Boslow
(Address) 1608 Jasper St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial
MM Auburn 6/29 1927

20 UNDERTAKER ADDRESS
Daniel Easton 916 Pa ave

25 1927 G. HAMPSON JONES M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 22655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 22655

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Dunaway

(a) RESIDENCE NO. 1744 N Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Walter Dunaway

(Address) 1720 N Calhoun St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to May 28, 1927,

that I last saw her alive on May 28, 1927,

and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (unresolved)

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis & Toxemia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) John W. Gaines, M. D.

, 19.. (Address) Providence Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Md Cem	May 30 1927
20 UNDERTAKER Hamel Easton	ADDRESS 916 Pa ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22656 — 129 — E 22656

1-PLACE OF DEATH St Joseph's Hospital. REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St. 12-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Elwood. Woodward.

(a) RESIDENCE NO. 2001 N. Charles. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Lula C Woodward.

6 DATE OF BIRTH (month, day, and year) Oct 21- 1872.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
54	53	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Repair man.

(b) General nature of industry, business, or establishment in which employed (or employer) O T B

(c) Name of employer U R R.

9 BIRTHPLACE (city or town)

(State or country) West. Virginia.

PARENTS

10 NAME OF FATHER Jack. Wood. ward.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Fannie Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Lula. Woodward.

(Address) 2001 N Charles St

Filed MAY 30 1927 C. HAMPSON JONES, M. D.

Per ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 27- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 11, 19 27, to May 27, 19 27,

that I last saw him alive on May 27, 19 27,

and that death occurred, on the date stated above, at 5:05 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis Chr. Nephritis.

Hypertension, Uraemia.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ———

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Frank R. De Paula, M. D.

, 19 (Address) 1323 N. Paths ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial MAY 30 1927 19

20 UNDERTAKER Geo W Little — ADDRESS EDMONDSON AVE.

Cor.—12-9-25—A Co.—200 Bks.

E 22657

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St. 120 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Jones

(a) RESIDENCE NO. 2000 Brent St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Jones

6 DATE OF BIRTH (month, day, and year) about 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John H Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lillian Jones

(Address) 626 Fremont

15 Filed G. HAMPSON JONES, M. D.

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26. 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (secondary) ecc history

(duration) yrs. mos. ds.

(Signed) J. H. Hemelong M. D.

(Coroner)

May 26 1927 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

Date of Burial May 30 1927

20 UNDERTAKER John H Owens

ADDRESS 338 Dallas

Spec.-7-17-26—A Co.—200 Bks.

E 22658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 22658

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3624 Maple Ave St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances V. Fox.

(a) RESIDENCE NO. 3624 Maple Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Zebdee Fox

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 60 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Zebdee Fox

(Address) 3624 Maple Ave

15 Filed ... 19 ... 1927 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to May 29th, 1927, that I last saw h[illegible] alive on May 26th, 1927, and that death occurred, on the date stated above, at 9.25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

Immediate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) W. F. Fleisal, M. D.

May 29, 1927 (Address) 261 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery Date of Burial: May 30 1927

20 UNDERTAKER: Chenoweth & Son ADDRESS 367 Chestnut Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22659

CERTIFICATE OF DEATH.

E 22659
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 Division St. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Augusta Wallace

(a) RESIDENCE NO. 1911 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William P Wallace

6 DATE OF BIRTH (month, day, and year) Aug 5, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	86	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mid Wife 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George W Pollard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jennie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anna McGinn

(Address) 1911 Division St

15 Filed MAY 29 1927 C. HAMPTON JONES, M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1926, to May 26, 1927, that I last saw h alive on May 26, 1927 and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis Chronic (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) age, Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical Symptoms

(Signed) Wm. N. Wright M. D.

5/27, 1927 (Address) 1209 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL 5/29/1927

20 UNDERTAKER Thos. Geo. H. Holland

ADDRESS 1601 David Hillard

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46

E 22660

1-PLACE OF DEATH E 22660 REGISTERED NO.

City of BALTIMORE: (No. 1910 Division St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Kerr

(a) RESIDENCE NO. 1910 Division St. St. 14 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. H. Kerr

6 DATE OF BIRTH (month, day, and year): Mar. 12-1857

7 AGE: Years 70 Months 2 Days 16 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Geo. L. Loydel

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Chas. H. Kerr

(Address) 1910 Division St.

15 Filed 5-28 1927 T. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1927 to May 24 1927

that I last saw h[illegible] alive on May 25 1927

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Hankins M. D.

, 19 (Address) 2027 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 5/31 1927

20 UNDERTAKER: Wm. Geo. H. Holland — ADDRESS 163 Druid Hill Ave

Spec.—12 9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22661

CERTIFICATE OF DEATH.

31

E 22661

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 S Poppleton St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E Truitt

(a) RESIDENCE NO. 12 S Poppleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42y mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ella Truitt

6 DATE OF BIRTH (month, day, and year): Mch 6 1885

7 AGE: Years 42 | Months 2 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: News Agent

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Isador Truitt

11 BIRTHPLACE OF FATHER (city or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Carma Clarke

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

14 Informant: Mrs Ella Truitt

(Address): 12 S Poppleton

15 Filed MAY 29 1927

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/27/27 19

17 I HEREBY CERTIFY, That I attended deceased from 5/24/27, 19, to 5/27/27, 19 27, that I last saw h— alive on 5/27/27, 19 27, and that death occurred, on the date stated above, at 9 4. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Apparent signs

(Signed) Samuel J. Levy, M. D.

5/27, 19 27 (Address) 916 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: 5/30/27

20 UNDERTAKER: George A Farley

ADDRESS: Fulton & Fayette

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22662

CERTIFICATE OF DEATH.

46 E 22662

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 822 (St.) Harlem (Ward) 17-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Henson

(a) RESIDENCE NO. 822 Harlem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Henson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 Years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Mark Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Blackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Albert Henson

(Address) 822 Harlem Ave

15 Filed 2-8 1927 G. HAMPSON JONES M.D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1926, to May 26, 1927.

that I last saw her alive on May 26, 1927

and that death occurred, on the date stated above, at 8:25 P.M.

THE CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. Garland Whitehead M.D.

May 29 1927 (Address) 1334 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 5/29/27

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1225 Ashland Ave

Spec.–7-17-26–A Co.–200 Bks.

E 22663.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 22663

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421, N. Enson St., 19-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A Stretch Jr

(a) RESIDENCE NO. 1421 N. Enson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Streb

6 DATE OF BIRTH (month, day, and year) Nov 10 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	52	6	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER Frank A. Streb Sr

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annett Tragasser

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Mrs Minnie Streb

(Address) 1421 N Enson St

15 Filed 9 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/18 19 27 to 5/27 19 27

that I last saw h alive on 5/26 19 27

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spine - (Metastatic)

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Pyemia & Uremia of a short

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wise M. D.

May 29 1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial May 30 1927

20 UNDERTAKER Geo M. Enderton — ADDRESS 811 N Wolfe

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22664

CERTIFICATE OF DEATH.

E 22664

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 N. Calhoun St. 16-23 Ward)

2-FULL NAME Doris Anne Spidgeon Spidgeon

(a) RESIDENCE NO. 633 N. Calhoun St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life lm. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 27 Mch 14/27

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Jas. N. Spidgeon

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country) D.C.

12 MAIDEN NAME OF MOTHER Mabel V. Nicholson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs Mabel Spidgeon

(Address) 633 N. Calhoun St

15 Filed MAY 30 1927 C. HAMPSON JONES, M. D. Registrar

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28/27 19

17 I HEREBY CERTIFY, That I attended deceased from May 20 19 27, to May 28, 1927, that I last saw h[illegible] alive on May 28, 1927, and that death occurred, on the date stated above, at 10:30 p m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia & Convulsions

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Mitral heart murmur

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. Arnold, M. D.

5/30 1927 (Address) 605 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial May 30 1927

20 UNDERTAKER John H. Fields ADDRESS 1200 N. Lombard

Spec.—1-10-21—M&T—1500 Bks.

E 22665

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22665

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 E Lombard ST. 16-37 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James White

(a) RESIDENCE NO. 3423 E. Lombard ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie White

6 DATE OF BIRTH (month, day, and year) Jan. 12 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer Penn. R.R.

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Nicholas White

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Carrie White

(Address) 3423 E. Lombard

15 May 28, 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 1st, 1927, to May 25, 1927, that I last saw h alive on May 25, 1927, and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lip

(duration) yrs. 16 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward N Athey M. D.

May 28, 1927 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 5/30/1927

20 UNDERTAKER J. J. Moran — ADDRESS 340 E. Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22666

CERTIFICATE OF DEATH.

31 E 22666

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Penitentiary Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jeter

(a) Residence No. 1711-W. Barnes St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Patterson Jeter

6-DATE OF BIRTH (month, day and year) March 22-1898

7-AGE. 29 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D+C

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Crewe, Va

PARENTS.

10-NAME OF FATHER Richard Jeter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Crewe, Va

12-MAIDEN NAME OF MOTHER, Mary Ransom

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Crewe, Va

14-

(Informant) Md. Penitentiary

(Address) 954 Forest Pl

15-

5/30 1927 C. HAMPTON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26 1927

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1927 to May 26, 1927

that I last saw him alive on May 26, 1927

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

(1) Pulmonary Tuberculosis

(2) Tuberculosis Peritonitis

(Duration) yrs. 5 mos. — ds

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam of Sputum

(Signed) Albert L. Anderson, M. D

5/26, 1927 (Address) 954 Forest Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Crewe Va

DATE OF BURIAL. May 30th 1927

20-UNDERTAKER, A. Jones

ADDRESS 111 S. Gilmor St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22667

CERTIFICATE OF DEATH.

129 E 22667

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted]

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Polaczyk (Polaczek

(a) RESIDENCE NO. 1103 E. Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 5 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Muller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Henn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

15 Filed 19 HAMPSON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 28, 1927, that I last saw h[illegible] alive on May 27, 1927, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gen'l & Lab'y

(Signed) G. D. Thorpe Smith M. D.

May 31 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial May 31 1927

20 UNDERTAKER Henry Hoeck & Son ADDRESS 1301 E Eager St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22668

CERTIFICATE OF DEATH.

101-001

E 22668

REGISTERED NO.....

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sartorius (John Ulrich Sartorius)

(a) RESIDENCE NO. 328 S. Patterson Park ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W Side

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	21	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk — 009

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Government

(c) Name of employer Clerk.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. W. Sartorius

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emma Ulrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr. George H. Sartorius
(Address) 328 S Patterson Park ave

15 Filed 3-8 1927 19 HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/7 1927 to 5/29 1927.
that I last saw h— alive on 5/29 1927
and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia —

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Axillary Abscess —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of 5/17

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gaetta, M. D.

5/29 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 1 1927

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 301 E Eager St

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

CERTIFICATE OF DEATH

E 22669 — 1-PLACE OF DEATH

E 22669 — REGISTERED NO.

City of BALTIMORE: (No. 1728 Chilton Street St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Kramer

(a) RESIDENCE NO. 1728 Chilton St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. Kramer

6 DATE OF BIRTH (month, day, and year) 7/10/1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employrr) D 31

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John Egan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Marg Egan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Edgar D Kramer

(Address) 1728 Chilton St

15 Filed MAY 30 1927, 19 HAMPSON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1924, to May 28, 1927

that I last saw h alive on May 28, 1927

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver -

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY Duodenal Hemorrhage

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanford McClung M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial May 31 1927

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22670

CERTIFICATE OF DEATH.

46

E 22670

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2062 Aiken St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace R. Sheeler

(a) RESIDENCE NO. 2062 Aiken St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Royden C. Sheeler

6 DATE OF BIRTH (month, day, and year): Sept. 11, 1892

7 AGE: Years 34 Months 8 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret L. Flaherty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant (Address): Royden C. Sheeler 2062 Aiken St.

15 Filed MAY 30 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1926, to May 27, 1927, that I last saw h.. alive on May 27, 1927, and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 1925

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) K. L. Gordy M. D.

5-27. 1927 (Address) 421 Hilton Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial May 30 1927

20 UNDERTAKER: Wilson Cook ADDRESS 503 E. Walbe

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22671

CERTIFICATE OF DEATH

100-001 ✓

E 22671

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2726 Belair Rd St.) (Ward) 27-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sopp

(a) RESIDENCE NO. 2726 Belair Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew A Sopp

6 DATE OF BIRTH (month, day, and year): Sept 29, 1863

7 AGE: Years 63 Months 8 Days 29. IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: Louis Miller

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Applehorn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Andrew Sopp

(Address) 2726 Belair Rd

15 Filed MAY 30 1927

19 HAMPSON JONES, M. D. Registrar

Per KK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1927, to May 28th, 1927, that I last saw h[illegible] alive on May 28th, 1927, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary): Nephritis

(duration) 2 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A Hut, M. D.

5/28, 1927 (Address) Ended.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

Date of Burial: May 31 1927

20 UNDERTAKER: H M Cook

ADDRESS: 502 E Monument

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 28 91

2 E 22672

CERTIFICATE OF DEATH.

X 100-001 E 22672

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John (Stefik) Siejak

(a) RESIDENCE NO. German Hill Road, Sparrows Pt Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
1 9 mos	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Stefik

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Rosie Kluszczewska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Pearl's JOHNS HOPKINS HOSPITAL

(Address)

15 Filed 30 1927 C. HAMPTON JONES, M. D.

Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 28 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to May 28, 1927, that I last saw h[illegible] alive on May 28, 1927, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia -

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Malnutrition & secondary

(Secondary)

anemia - (duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Price -, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Date of Burial May 31 1927

20 UNDERTAKER John W. Weber ADDRESS 1803 Bank

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22673

CERTIFICATE OF DEATH.

179 E 22673

1-PLACE OF DEATH
City of BALTIMORE: (No. Pronounced dead at the South Baltimore General Hospital Ward) Out-34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Daumann.

(a) RESIDENCE NO. 729 E. Fort Ave St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced, HUSBAND of (XXXXXXX): Eleanore Daumann.

6 DATE OF BIRTH (month, day, and year): March 17, 1860

7 AGE — Years: 67 — Months: 2 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Basket maker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town):
(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George Daumann.

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Rosina Schelhorn.

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany.

14 Informant: Eleanore Williams. (daughter)
(Address): 1316 William St.

15 Filed 30 1927 C. HAMPSON JONES, M. D. Registrar For LK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Occiental burns about the face and body. Fell over an oil stove.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Steinhardt M. D.
(Coroner)

5/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? 729 E. Fort Ave. May 27° 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int. Elvict — Date of Burial: 5/30 1927

20 UNDERTAKER: J. J. Fahy Sons — ADDRESS: 1348 Light St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22674 — 1-PLACE OF DEATH — REGISTERED NO. E 22674

CITY OF BALTIMORE: (No.) 575 Dolphin ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Virginia Gray

(a) RESIDENCE NO. 575 Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE: Years 56 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Reuben White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Iler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Gray 575 Dolphin St.

15 Filed 0 1927, 19 C. HAMPTON JONES, M. D. Registrar. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1927, to May 26, 1927, that I last saw h[illegible] alive on May 26, 1927, and that death occurred, on the date stated above, at 650 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Carey, M. D.

, 19 (Address) 1[illegible] Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL 5/31 1927

20 UNDERTAKER: Samuel J. Bradley — ADDRESS 7[illegible] W Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22675

E 22675

REGISTERED NO.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ____ St. 13-59 Ward 45)

2-FULL NAME Reuben Davis

(a) RESIDENCE NO. 2546 McCulloh St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) reckon May 27-1852

7 AGE 75 Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) South Carolina

PARENTS

10 NAME OF FATHER ditto

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) ditto

12 MAIDEN NAME OF MOTHER ____

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) ditto

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 30 1927 19 C. HAMPSON JONES, M. D. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1927, to May 27, 1927, that I last saw h.. alive on May 27, 1927, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of large intestine with perforation into the stomach

(duration) not known yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) partial intestinal obstruction

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of April 23, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Cem	5/31 1927
20 UNDERTAKER Samuel H. Hensley	ADDRESS 578 N. Eddle

Spec.-7-17-26—A Co.—200 Bks.

E 22676

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22676

CERTIFICATE OF DEATH

118-001

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Maryland General Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Leppler

(a) RESIDENCE NO. 2117 West Balto. St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (Write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Louis Leppler

6 DATE OF BIRTH (month, day, and year): 6-20-1859

7 AGE — Years: 67 Months: 9 10 Days: 28 29

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Leonard Hoeflich

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Hosp. Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 5-28-27

17 I HEREBY CERTIFY, That I attended deceased from 5-28-27, 19, to 5-28-27, 19,

that I last saw h alive on 5-28-27, 19,

and that death occurred, on the date stated above, at 6.40 P. M.

The CAUSE OF DEATH* was as follows:

Strangulated Ventral Hernia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-28-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. E. Zumwinkle M. D.

, 19 (Address) Md. Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Jan 31 19 27

20 UNDERTAKER: George L. Ashwal — ADDRESS: 2[illegible] Fulton Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22677 (Franklin Square Hosp.) 111-E 22677

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3524 Wilkens (St.) 25-14 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Christian Burr

(a) RESIDENCE NO. 3524 Wilkins Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Burr.

6 DATE OF BIRTH (month, day, and year): Jan 29 1860

7 AGE: Years 67 Months 4 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): tin Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Berghardt Burr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Roelle

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 Informant: Mrs. Marie E. Burr

(Address) 3524 Wilkens Ave.

15 Filed: 30 1927 19 Registrar: C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to May 29, 1927, that I last saw him alive on May 29, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Perforated duodenal ulcer

Appendicitis (subacute)

Peritonitis.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Perforated ulcer duodenal.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 13, 1927

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) W. W. Walker, M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: June 1 1927

UNDERTAKER: George Schwartz ADDRESS: 2011 Fleet Ave.

Spec.—12-9-25—A Co.—200 Bks.

E 22678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 521 Patapsco av. St., Brooklyn Ward)

2-FULL NAME Althea Lillian Moog

(a) RESIDENCE NO. 521 Patapsco av Brooklyn Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Oliver Moog

6 DATE OF BIRTH (month, day, and year): 1, 16 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jas Kirwan

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Dorchester Co Md

12 MAIDEN NAME OF MOTHER: Margaret Ghent

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Oliver Moog

(Address): 521 Patapsco av Brook

15 Filed....., 19.....

C. HAMPTON JONES, M. D.

Per ....., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1927

17

I HEREBY CERTIFY, That I attended deceased from January 1st, 1927, to May 27, 1927, that I last saw her alive on May 27, 1927, and that death occurred, on the date stated above, at 8.0 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Durlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: 5/30/1927

20 UNDERTAKER: C. J. Fanning & Son — ADDRESS: 1460 Battery ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23579 89 E 20679

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 E 33rd ST. (WARD) 17-50

2-FULL NAME Lucy Daugherty

(a) RESIDENCE NO. 213 East 33rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos Edwin Daugherty

6 DATE OF BIRTH (month, day, and year) June 29-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	80	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Matthews Co. Va

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah E. Bohannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs M. A. Daugherty

(Address) 213 E 33rd St

15 Filed MAY 30 1927 HAMPSON JONES, M. D. Registrar

Per P.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to May 29, 1927, that I last saw h[illegible] alive on May 28, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina

(duration) yrs. mos. 12 hours ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lenhossin, M. D.

5/29/1927 (Address) 8409 Dallamy Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL May 30 1927

20 UNDERTAKER Mrs J Tuckner Jones — ADDRESS [illegible]

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22680

E 22680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 33

CITY OF BALTIMORE: (No. 1069 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Rose

(a) RESIDENCE NO. Franklin + Calverton ST. Roads WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Black.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) House of Good Shepherd Calverton Rd. + Franklin St

15 Filed 3 T 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1927 to 5/29, 1927 that I last saw her alive on 5/29, 1927 and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) T.B. Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guerta, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery DATE OF BURIAL May 31 1927

20 UNDERTAKER George L. Lohrer ADDRESS 2101 Eutaw Pl.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22681

CERTIFICATE OF DEATH.

49 ✓

E 22681

1-PLACE OF DEATH The Church Home & Infirmary

REGISTERED NO.

City of BALTIMORE: (No.) St. 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME McDiarmid, Fred

(a) RESIDENCE NO. Raeford, North Carolina St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Ruth McDiarmid

6 DATE OF BIRTH (month, day, and year) Mar 15 1876

7 AGE: Years 51 | Months 2 | Days 15 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Alabama

PARENTS

10 NAME OF FATHER Norman McDiarmid

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary J. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Norman McDiarmid

(Address) Raeford N. C.

15 Filed MAY 31 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1927, to May 30, 1927, that I last saw him alive on May 30, 1927, and that death occurred, on the date stated above, at 4/20 P. m.

The CAUSE OF DEATH* was as follows:

Papilloma antrum of Highmore, Left.

(duration) ? yrs. mos. Ans

CONTRIBUTORY (Secondary) Septicaemia Autopsy

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Not in hospital Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Henry O'C Wilson & M.D., M. D.

, 19 (Address) The Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fayetteville N. C. Date of Burial 5/31 1927

20 UNDERTAKER J. G. Moran ADDRESS 3000 E. Baltoh.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22682

CERTIFICATE OF DEATH

E 22682

REGISTERED NO. 1130

1-PLACE OF DEATH

City of BALTIMORE: (No. 1061 W Fayette St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Childs Rudge

(a) RESIDENCE NO. 1061 W Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
		2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John Rudge

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Edna Day

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Geo A Day

(Address) 1061 W Fayette

15 Filed MAY 31 1927 C. HAMPSON JONES, M. D. Registrar Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1927, to May 30, 1927

that I last saw him alive on May 29, 1927

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) ✓ yrs. one mos. 3 da.

CONTRIBUTORY None

(Secondary)

(duration) ✓ yrs. ✓ mos. ✓ da.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. E. Blake, M. D.

May 31 1927 (Address) 203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Date of Burial May 31 1927

20 UNDERTAKER John O Mitchell and Son ADDRESS 1900 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22683

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Greene St. 16-22 Ward) 161-02

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Gorden

(a) Residence No. 1538 W. Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-23-27

7-AGE ....yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER Lewis O. Gorden

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Margaret Long

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant)

(Address)

15- Filed 3-1 1927 192 R. H. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-24-27

17- I HEREBY CERTIFY, That I attended deceased from 5-23 19 27 to 5-24 19 27

that I last saw h[illegible] alive on 5-24 19 27

and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Maternal Placenta Praevia - (Caesarean Section)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Partial Congenital atelectasis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Ed Dodge M. D.

, 19 (Address) Univ. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cemetery Hosp. DATE OF BURIAL. ..... 19...

20-UNDERTAKER. ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22684

E 22684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 323 E. 30th St 12-50 St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annabelle W. Pardew

(a) Residence No. 323 E. 30th St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 29-1899

7-AGE. 27 yrs. 11 mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER Rev. Jeremiah R. Pardew

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Mariah E. Mallow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Rev. Jeremiah R. Pardew

(Address) 323 E. 30th St

15- Filed, 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 30. 1927

17- I HEREBY CERTIFY, That I attended deceased from May 26, 1927 to May 30, 1927 that I last saw her alive on May 30, 1927 and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcic Sore Throat

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Septicemia, pneumonia

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course of disease

(Signed) Geo. M. Gitt M.D.

5/30, 1927 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. June 1, 1927

20-UNDERTAKER. Josiah Eyler ADDRESS 1600 N. Paca ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22685

CERTIFICATE OF DEATH

E 22685

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals S.E.B. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Webster Walton

(a) RESIDENCE NO. 406 E. Chase st. St. Ward

(Usual place of abode) Unknown

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 - 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
45	46	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. R. Walton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Gittings

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed MAY 31 1927 19 HAMPSON JONES, M. D. Registrar

RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 27, 19 27, to May 28, 19 27,

that I last saw him alive on May 28, 19 27,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY Tuberculous Laryngitis
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) M. E. Gittings, M. D.

5-28-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial May 31 1927

20 UNDERTAKER W. J. Cook

ADDRESS Govt Work

Spec. –7-17-26—A Co.—200 Bks.

E 22686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22686

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) 5004 Alhambra Ave St. (Ward) 27-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Norris

(a) RESIDENCE NO. 5004 Alhambra Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jessie H Norris

6 DATE OF BIRTH (month, day, and year): July 28, 1838

7 AGE — Years: 88 Months: 10 Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Fork Brook

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Edmund Norris

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Emily Stephens

(Address): 5004 Alhambra Ave

Filed MAY 31 1927 19 [illegible] JONES M D Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927, to May 28th, 1927, that I last saw him alive on May 27th, 1927, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Organic Heart Disease Hemiplegia - Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age - Pneumonia

Jaundice Aplasia (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms & Findings

(Signed) Chas Jones, M. D.

, 19 (Address) 2802 - Rusdyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: May 31 1927

20 UNDERTAKER: William Cook — ADDRESS: 507 Eutaw

Dr Fenby - Grunmount Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22687

CERTIFICATE OF DEATH

E 22687

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: No. 519 Chestnut Hill Ave St. (Ward) 7-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Busick

(a) RESIDENCE NO. 519 Chestnut Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Daniel J Busick

6 DATE OF BIRTH (month, day, and year): Jan 14 1863

7 AGE: Years 64 Months 4 Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: James Gregory

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Sparks

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Mary E Mulloy

(Address): 511 E 34th St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to May 29, 1927, that I last saw h[er] alive on May 29, 1927, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis & Arterial Hypertension (duration) 3 yrs. 3 mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John D. Fenby, M. D.

5/28, 1927 (Address) 3527 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial 5/31/27

20 UNDERTAKER: [illegible] ADDRESS 500 E Lafayette

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22688 E 22688

CERTIFICATE OF DEATH

1-PLACE OF DEATH ~~John Oliver Dandy Jr.~~ REGISTERED NO. 13-52

City of BALTIMORE: (No. 626 W 33d St. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Oliver Dandy

(a) RESIDENCE NO. 626 W 33d St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) January 14, 1926

7 AGE Years 1 Months 5 Days 16 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John O Dandy

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Gladys Kromm

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Hospital Records U.M.H.

(Address)

15 Filed MAY 31 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to May 24, 1927, that I last saw him alive on May 30 1927 and that death occurred, on the date stated above, at 10-25 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma, kidney, left

(duration) at least 2 mos ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? yes Date of 4/10/27

Was there an autopsy? no

What test confirmed diagnosis? operation, clinic & lab. method

(Signed) Randolph Smith, Jr., M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial June 2 1927

20 UNDERTAKER William Cahoon ADDRESS 2028 Madison

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22689 E 22689

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH 1523 E. Fairmount Ave

CITY OF BALTIMORE: (No. ..... ST., 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa May Kemp

(a) RESIDENCE NO. 1523 Fairmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18 1904

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
22 23	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Raleigh N.C

PARENTS

10 NAME OF FATHER Jesse Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N.C

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh N.C

14 Informant Jesse Kemp
(Address) 1941 Sterling Street

15 Filed MAY 31 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 — 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-28 .1927. to 5-29 .1927.

that I last saw h alive on 5-28 .1927

and that death occurred, on the date stated above, at 4p 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL 6/1 1927

20 UNDERTAKER Byrow & Wright

ADDRESS 1218 McElderry St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22690

CERTIFICATE OF DEATH

E 22690

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 415 E. Biddle St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ohlgan Sr.

(a) RESIDENCE NO. 415 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Ohlgan

6 DATE OF BIRTH (month, day, and year): Dec 1 – 1846

7 AGE: Years 80 Months 5 Days 28 IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Geo. P. Ohlgan

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Geo. P. Ohlgan

(Address) 415 E. Biddle St.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

Per F H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 27, 19 27, to May 29, 19 27, that I last saw h.. alive on May 29, 19 27 and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff..

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary): Carcinoma Stomach

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. W. Bowers, M. D.

, 19 (Address) 812 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

Date of Burial: June 1st 1927

70 UNDERTAKER: Wilbur W. Shriver

ADDRESS 1018 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

E 22691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22691

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No.) St. 18-26 (Ward)

2-FULL NAME William Meekins.

(a) RESIDENCE NO. 834 Pierce St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col—

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-10-14

7 AGE: Years 12 12 yrs; Months 9; Days 18; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Edgar Meekins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Nellie Meekins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Records

15 Filed JUN 3 1927 19 R.K., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

28 May 1927

17

I HEREBY CERTIFY, That I attended deceased from 24 May, 19 27, to 28 May, 19 27, that I last saw him alive on 28 May, 19 27, and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 3 weeks mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial May 30/1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pine

Spec.–7-17-26—A Co.—200 Bks.

Tasker

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22692

CERTIFICATE OF DEATH

40

E 22692

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Tasker -

(a) RESIDENCE NO. 1832 Division St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 31 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland.

(State or country)

PARENTS

10 NAME OF FATHER David Tasker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Joanda Douglas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Robert Tasker

(Address) 1832 Division St

15 Filed 31 1927, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 27, 1927

that I last saw h[illegible] alive on May 27, 1927

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pelvic Surgery - Disease -

Peritonitis. (Gangrene)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Purulent Ileus -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical Specimen

(Signed) H. Bruce M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: May 31 1927

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 393 Preston St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

CERTIFICATE OF DEATH

E 22693 REGISTERED NO. E 22693

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 S Paca St., 22 Ward) 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Demarco

(a) RESIDENCE NO. 414 S Paca St. 22 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~write the word~~): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Maria Demarco

6 DATE OF BIRTH (month, day, and year): May 5-1849

7 AGE: Years 78 Months 0 Days 24 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Non.

(b) General nature of industry, business, or establishment in which employed (or employer): non

(c) Name of employer: non

9 BIRTHPLACE (city or town) Cefalu (State or country) Sicily Italy.

PARENTS

10 NAME OF FATHER Salvatore Demarco

11 BIRTHPLACE OF FATHER (City or town) Cefalu (State or country) Sicily Italy.

12 MAIDEN NAME OF MOTHER Pirara

13 BIRTHPLACE OF MOTHER (city or town) Cefalu (State or country) Sicily Italy.

14 Informant S. Demarco (Address) 1604 Linden ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 1927

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 19, to 5-29 1927

that I last saw him alive on 5-29 1927

and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Pathological Gall bladder

Gastric ulcer

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Demarco, M. D.

5-30 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: June 1927

20 UNDERTAKER: Geo M. Frick & Son ADDRESS: Eutaw

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 22694

E 22694 CERTIFICATE OF DEATH REGISTERED NO.

47-56

City of BALTIMORE: (No. 4750 Park Heights Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Redman

(a) RESIDENCE NO. 4750 Park Heights Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Redman

6 DATE OF BIRTH (month, day, and year) May 29, 1846

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	80	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER John Hamill

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sallie Ewing

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. George Busch

(Address) 4750 Park Heights Ave.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1927, to May 29, 1927

that I last saw h[illegible] alive on May 29, 1927

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Tyler M.D.

, 19 (Address) 4814 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial June 1927

20 UNDERTAKER John H. Denny — ADDRESS 715 Light

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22695

CERTIFICATE OF DEATH.

× 90

E 22695

1-PLACE OF DEATH Pronounced dead at the

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Briscoe.

(a) RESIDENCE NO. Annapolis Blvd. & 1st St. Brooklyn Park.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 7 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXX Daisy V. Briscoe.

6 DATE OF BIRTH (month, day, and year) November 20, 1873.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman, National

(b) General nature of industry, business, or establishment in which employed (or employer) Enameling & Stamping Company.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William T. Briscoe.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah J. Fardwell.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Thomas J. Briscoe. (brother)

(Address) 248 Washington St. Frederick, Md.

15 Filed MAY 31 1927 HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. Steinhardt M. D. (Coroner)

5/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? National Enameling & Stamping Co. 5/27/27

xxxxxxxxxxxxxxxxxx Light & Webb Sts.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial May 31 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22696

CERTIFICATE OF DEATH.

84 E 22696

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2213 Linden Ave St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saml Hamburger

(a) RESIDENCE NO. 2213 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) March 4/1869

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
58	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Hamburger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Bruchet

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Gilbert Fromdlock

(Address) 200 W. Balto St.

15 Filed MAY 31 1927 HAMPSON JONES M. D. Registrar

Par RA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to May 30, 1927, that I last saw h.... alive on May 30, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis (coronary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I. Fred Semler Lent, M. D.

May 31, 1927 (Address) Temple Garden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cemetery Date of Burial June 1/27

20 UNDERTAKER Ahearn & Co ADDRESS 331 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22697

CERTIFICATE OF DEATH.

118-002

11-22

E 22697

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Gen Lecom Hospital (Street) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie H. N. Beecher

(a) RESIDENCE NO. 103 N. Fulton Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of J. Gregg Beecher

DATE OF BIRTH (month, day, and year) May 6 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Arthur H. Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Anne E. MacGill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant J. Gregg Beecher

(Address) 103 N. Fulton Ave

Filed 6-1 1927 Rjc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to May 30, 1927,

that I last saw h alive on 5/29/27 1927

and that death occurred, on the date stated above, at 7 45 a

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fecal Impaction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Ye Date of 5/29/27

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. Cecil Ely, M. D.

, 19 (Address) 25-30 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 1 1927
20 UNDERTAKER	ADDRESS
Wm J. Dickner & Sons	N. Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 22698 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22698

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4113 Belview Ave ST., 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia C. Lloyd

(a) RESIDENCE NO. 4113 Belview Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Lloyd.

DATE OF BIRTH (month, day, and year) Dec, 17, 1849

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ohio.

10 NAME OF FATHER John P. Conradi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Sprung

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. Alvin P. Lloyd.

(Address) 4113 Belview Ave.

Filed 3-1 1927 Per R.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to May 29, 1927.

that I last saw her alive on May 29, 1927,

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 7 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of gall-bladder

(duration) about 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carroll Lovland, M. D.

May 30 1927 (Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL May 31 1927

20 UNDERTAKER Wm. H. Eichenlaub Sons. ADDRESS Northern

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22699

CERTIFICATE OF DEATH

E 22699

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 535 N. Kenwood Ave St. 9-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. McGeeney

(a) RESIDENCE NO. 535 N. Kenwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 10 1883

7 AGE: Years 43 Months 5 Days 19 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Owen J. McGeeney

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Yates

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs Elizabeth McGeeney

(Address) 535 N. Kenwood Ave

15 Filed 5 31 1927 19 H. HAMPTON MOORE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from About 19 19 to May 29 19 27

that I last saw her alive on May 28 19 27

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 12 ds.

CONTRIBUTORY Mitral Stenosis

(Secondary) Auricular Fibrillation

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carroll Pollard, M. D.

(Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: 6/2nd 1927

20 UNDERTAKER: Chas. P. Maus & Son — ADDRESS: 1118 N. Howard

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22700

CERTIFICATE OF DEATH

90 E 22700

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1900 Garrison Av St., 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regis B Larogue

(a) RESIDENCE NO. 1900 Garrison St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Green Larogue

6 DATE OF BIRTH (month, day, and year) Jan 19 — 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
69	68	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Paris Md

(State or country)

PARENTS

10 NAME OF FATHER Emile Philip Larogue

11 BIRTHPLACE OF FATHER (City or town) Paris. Md

(State or country)

12 MAIDEN NAME OF MOTHER Adelaide Virginie Dezmond

13 BIRTHPLACE OF MOTHER (city or town) Paris. Md

(State or country)

14 Informant Rosine S. Larogue

(Address) 1900 Garrison Av.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May. 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to May 30, 1927

that I last saw h~~is~~ alive on May 30, 1927

and that death occurred, on the date stated above, at 3-9 m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L Stamford M. D.

5/30. 1927 (Address) 2806 Barrison Av

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 6/1 1927

20 UNDERTAKER Chas P. Maus & Son 118 W Mt Royal ave — ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22701

CERTIFICATE OF DEATH

32

E 22701 REGISTERED NO.

1-PLACE OF DEATH St Joseph Hospital
City of BALTIMORE: (No. Caroline & Eden St. 15-23 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Davis

(a) RESIDENCE NO. 1457 N. Carey St St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 7 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas L. Davis
11 BIRTHPLACE OF FATHER (City or town) Va.
(State or country)
12 MAIDEN NAME OF MOTHER Anna Woods
13 BIRTHPLACE OF MOTHER (City or town) Prince George Co Md
(State or country)

14 Informant Chas L. Davis
(Address) 1457 N. Carey St

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 28, 1927, that I last saw h[illegible] alive on May 28, 1927, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

I. P. Meningitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted St Joseph
if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Clement G Bowers, M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: 5-31 1927

20 UNDERTAKER: George A. Gibson — ADDRESS: 1735 Druid Hill Ave

K H

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22702

CERTIFICATE OF DEATH

100-001

E 22702

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2112 Harford Ave. Ward 9-46)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lewis

(a) RESIDENCE NO. 2112 Harford Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 6-1869

7 AGE: Years 57 Months 8 Days 23

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Rammung

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Meinmuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine M. Eagan

(Address) 2112 Harford Ave

MAY 31 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927, to May 29, 1927, that I last saw her alive on May 28 1927, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Nephritis, parenchymatous, acute

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, lobar

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Hyaline Casts

(Signed) L. H. Fleetwood, M. D.

19 (Address) 1300 St Paul 5/30/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial June 1 1927

20 UNDERTAKER: John Ullrich — ADDRESS 2118 Orleans

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22703

E 22703

CERTIFICATE OF DEATH

REGISTERED NO. 49

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. —— St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wurtz

(a) RESIDENCE NO. 2038 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17-1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg dept 080

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Philadelphia

9 BIRTHPLACE (city or town) Philadelphia

(State or country)

PARENTS

10 NAME OF FATHER John R Wurtz

11 BIRTHPLACE OF FATHER (City or town) Philadelphia

(State or country)

12 MAIDEN NAME OF MOTHER Anna Bierman

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia

(State or country)

14 Informant John R Wurtz

(Address) 3724 Belair road

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to May 31, 1927, that I last saw h alive on May 31 st 1927, and that death occurred, on the date stated above, at 1 45 m.

The CAUSE OF DEATH* was as follows:

Cancer of Eye - +

(note: pt previously admitted to hospital Mar 26-'27 Left Hospital & was readmitted May 27 '27 - Had operation 3 sessions.) (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Central Embolism -

Exophthalmic Goiter (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? No Date of 2 operations 2 times

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Biopsy

(Signed) Clement R Thomson, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia

Date of Burial June 2 1927

20 UNDERTAKER John Ulrich

ADDRESS 2107 Orleans

Spec.—1-10-21—M&T—1500 Bks.

E 22704

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22704

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3048 Guilford Ave ST. 12-50 WARD)

2-FULL NAME Louis Birkmeyer

(a) RESIDENCE NO. 3048 Guilford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Birkmeyer

6 DATE OF BIRTH (month, day, and year) Oct. 30 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John F. Birkmeyer Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Flizabeth Fullbauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Birkmeyer
(Address) 3048 Guilford Ave.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1927 to May 28 1927,
that I last saw him alive on May 27 1927,
and that death occurred, on the date stated above, at 530 A m.
The CAUSE OF DEATH* was as follows:

Prostatic Carcinoma

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) Leonard E Rusch M. D.
1927 (Address) 2229 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL May 31 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N Eutaw St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22705

CERTIFICATE OF DEATH.

3V

REGISTERED NO. E 22705

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 3-4 WARD)

2-FULL NAME Virginia James

(a) RESIDENCE NO. 302 S. Bethel St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 12, 1923

7 AGE: Years 4 | Months 2 | Days 16 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Earl James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Ethel Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ethel Jordan

(Address) 302 S. Bethel St

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to May 28, 1927, that I last saw her alive on May 28, 1927, and that death occurred, on the date stated above, at 12 15 P m

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Myron G. Tull, M. D.

5/31, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Not Given

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wendell & Keppel

DATE OF BURIAL: May 31, 1927.

20 UNDERTAKER: Wendell & Keppel

ADDRESS: 310 N. Eden St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22706

CERTIFICATE OF DEATH.

198 E 22706

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun Hospital St. 5-9 Ward)

2-FULL NAME Edgar Bailey

(a) RESIDENCE NO. 213 N Edea. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Bailey

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 41 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Elexander Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Lizzie Slater

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Lizzie (Coroner)

(Address): 213 N. Eden st

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide

Stab Wound of Head

Lacerations of Brain

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ... yrs. ... mos. 1 ds.

May 30 27 (Signed) G. C. Pides M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md. Date of Burial May 31 1927

20 UNDERTAKER: Edward Bryan ADDRESS 631 Orleans st.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22707

CERTIFICATE OF DEATH.

101-007

E 22707

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 S. Decker Ave ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Lentz

(a) RESIDENCE NO. 736 S. Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lentz

6 DATE OF BIRTH (month, day, and year) Aug. 9-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Herman Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Henry Lentz

(Address) 736 S. Decker ave

Filed MAY 31 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1927 to May 29, 1927, that I last saw h[illegible] alive on May 29, 1927 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Tubar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Lung involvement X-ray + mother

(Signed) [illegible] M. D.

5/29, 1927 (Address) 3015 Clifford Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	June 1 1927
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22708

CERTIFICATE OF DEATH.

33 E 22708

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 W. Lexington St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Chapman

(a) Residence No. 1029 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Chapman

6-DATE OF BIRTH (month, day and year) Jan. 13, 1883

7-AGE, 44 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None particularly

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Chas Chapman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Alice Savington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Emma Coonan

(Address) 514 N. Calhoun St.

15- Filed 5 31 1927 C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29, 1927

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to May 29, 1927, that I last saw h. alive on May 29, 1927, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal phthisis

(Duration) 1 yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Mayo Williams M. D.

5-30-1927 (Address) 830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL, June 1, 1927

20-UNDERTAKER Joseph A. Lindy — ADDRESS 408 N. Howard St.

Spec.—1-12-23—M&T—500 Blks.

E 22709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 . E 22709

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1900 McCulloh. ST. 14 WARD 20)

2-FULL NAME Ellean Jones

(a) RESIDENCE NO. 1900 McCulloh. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 21 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Thomas Jones

6 DATE OF BIRTH (month, day, and year): 1904

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S.C.

10 NAME OF FATHER: Lown Furgeson

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER: Dora Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

Informant: Lown Furgeson

(Address): Pat Lansburg S.C.

Filed 1927, 19 C. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-29- 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-28- , 1927 , to 5-29- , 1927 ,

that I last saw h— alive on 5-29- , 1927

and that death occurred, on the date stated above, at 4,30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Hampton , M. D.

5-30-, 1927 (Address) 611- N Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pat Lansburg S.C.	May 3/1927
20 UNDERTAKER: Samuel Ekinsley	ADDRESS: 336 W Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22710 E 22710

CERTIFICATE OF DEATH.

118-002

17-24

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 Hanover St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Slaughter

(a) RESIDENCE NO. 504 Hanover St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Slaughter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Miles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Pearl Slaughter

(Address) 567 Greenmount Ave

Filed May 31 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

May 28 19 27 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial June 1 1927

20 UNDERTAKER Ernest Hawley ADDRESS 5[illegible] N Bdle

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22711

CERTIFICATE OF DEATH

46

E 22711

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. St. 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Manning

(a) RESIDENCE NO. 1931 Penna Ave, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 55 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Elijah Jones

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Lottie Wilson

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Louise Rosa (Address) 1931 Penna Ave

15 Filed JUL 1927 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/29/27, 19, to 5/28, 19 27

that I last saw her alive on 5/27, 19 27

and that death occurred, on the data stated above, at 4:30 P. m.

THE CAUSE OF DEATH* was as follows:

Abdominal Tumor

?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion of Ovaries ?

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 5/27/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) John B. Graham, M. D.

19 (Address) Colonial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. Date of Burial: May. 31 1927

20 UNDERTAKER: Samuel Ormsby ADDRESS: 1778 Bolton

Spec.–7-17-26—A Co.—200 Bks.

E 22712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22712

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (E.B.) Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Street

(a) RESIDENCE NO. 411 N. Exeter st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 4 1850 Nov 19

7 AGE: Years 72 Months 6 Days 9 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Sam'l. Street

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Easton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant:

(Address) Hospital Records

Filed 5-31 1927 C. HAMPSON JONES, M. D. Registrar

RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 22, 19 27 to May 28, 19 27

that I last saw him alive on May 28, 19 27,

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Aortic insufficiency

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Gatling M. D.

5-28-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md — Date of Burial: June 1 1927

20 UNDERTAKER: George J. Smith — ADDRESS 153 Hollins

Spec.—12-9-25—A Co.—200 Blks.

E 22713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22713

REGISTERED NO. 90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward) 76-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dayle

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER — Doyle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14

Informant

(Address) Medical Records

Filed MAY 31 1927, 19

By [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to May 29, 1927, that I last saw h[illegible] alive on May 29, 1927, and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 7 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lintt, M. D.

May 29 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Patuxent Cem Date of Burial June 1 1927

20 UNDERTAKER Peter Nicolaas ADDRESS 923 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

E 22714 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 642 S. Linwood Ave St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John George Kelch

(a) Residence No. 642 S. Linwood Ave St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kelch

6-DATE OF BIRTH (month, day and year) May 18, 1856

7-AGE. 71 yrs. 0 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Driver of D.D.

(b) General nature of industry, business, or establishment in which employed (or employer). delivery wagon

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. George Kelch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Wagner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Elizabeth Kelch

(Address). 642 S. Linwood Ave

15-

Filed..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29, 1927

17- I HEREBY CERTIFY, That I attended deceased from May 20th 1927 to May 29, 1927 that I last saw him alive on May 27, 1927, and that death occurred, on the date stated above, at 4 50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach + small intestine

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary) Cardiac degeneration

(Duration) yrs. 2 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 5, 1927

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George F. Kuiper M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	May 31, 1927
20-UNDERTAKER.	ADDRESS
Peter Nicolaus	923 Eastern Ave

ST 1927 Hamp

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22715

CERTIFICATE OF DEATH.

E 22715

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No.) St., 9-46 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Tefel

(a) RESIDENCE NO. 2813 Frisby St St. Ward H & H 44

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Boy

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April - 8 - 1925

7 AGE: Years 2 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Tefel

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Mel

12 MAIDEN NAME OF MOTHER Mary Hopper

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Mel

14 Informant (Address) Records Johns Hopkins Hospital

15 JUN 1927, 19 C. HARRISON JONES, M. D. Registrar

Per Roy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from April 2 19 27, to May 30, 19 27, that I last saw h[illegible]alive on May 30, 19 27 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Cardiac Failure.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 5-2-27.

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) J. W. Schacht, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery Date of Burial: June 3 19 27

20 UNDERTAKER: Ralph J. Turner ADDRESS: 4 W. Biddle

Spec.—12-9-25—A Co.—200 Bks.

E 22716

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22716

CERTIFICATE OF DEATH.

129

28-64

1-PLACE OF DEATH

City of BALTIMORE: (No. 4802 Ferndale ave. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Jacobs.

(a) RESIDENCE NO. 4802 Ferndale ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Jacobs.

6 DATE OF BIRTH (month, day, and year) Oct 2nd 53

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	73	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Mordecai Jacobs.

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Hartlove

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant Mrs. Vaugn Lengar

(Address) 4802 Ferndale Ave.

15 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/27 19

17 I HEREBY CERTIFY, That I attended deceased from 2/23 19 27, to 5/29 19 27

that I last saw h im alive on 5/29 19 27

and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows: Chronic nephritis with Hypertension

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical Sym

(Signed) James Brown M. D.

, 19 (Address) 808 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral. Date of Burial 6/2/27.

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22717

CERTIFICATE OF DEATH.

E 22717

1-PLACE OF DEATH

City of BALTIMORE: (No. 4922 Park Heights Ave) (Ward) 24-5

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Harris Vanneman

(a) RESIDENCE NO. 4922 Park Heights Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): widow

6a If ~~married~~, widowed, ~~or divorced~~ (or) ~~HUSBAND of~~ WIFE of Robert E—

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Leo Harris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Leonard Vanneman

(Address) 4922 Park Heights Ave

15 1927 C. HAMPSON WHITE, M. D. Registrar

Reg

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Hemorrhage of Brain

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. Hamilton M. D.
(Coroner)

5/31, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilmington Del. Date of Burial May 3 1927

20 UNDERTAKER: W M Cook ADDRESS 502 E Balt St

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22718

CERTIFICATE OF DEATH.

69 E 22718

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 700 N. 27 St. 17-51 WARD)

2-FULL NAME Daniel Edward Magner

(a) RESIDENCE NO. 700 N. 27 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Sgl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 22. 1927

7 AGE: Years — Months 1 — Days 4 8 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Magner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Magner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Geo Magner (Address) 700 N 27th St

15 1927 C. HAMPSON JONES, M. D. 19 Per N.C.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to May 30, 1927. that I last saw him alive on May 30, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Purpura Haemorrhagica

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — —

What test confirmed diagnosis? —

(Signed) E. J. Marx, M. D.

5.31. 1927 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: 5-31 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Cathedral

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22719 E 22719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Ashburton St. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Rhoney

(a) RESIDENCE NO. 1110 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leo A. Rhoney

6 DATE OF BIRTH (month, day, and year): Nov 13-1885

7 AGE: Years 41 40 | Months 6 | Days 18 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bellwood Penn.

PARENTS

10 NAME OF FATHER: Wm Alex Barnet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Blanche Dania

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lumberland, Penn.

14 Informant: Leo A. Rhoney

(Address): 1110 Ashburton St.

15 Filed 1-1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1927, to May 28, 1927, that I last saw her alive on May 28, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia Hemorrhagica

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no Physical Exam

What test confirmed diagnosis?

(Signed) John A. Graham M. D.

5/30, 1927 (Address) 1219 Eastland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6-1-1927

20 UNDERTAKER: Harry C. Browning & Son — ADDRESS: 5[illegible] St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22720

CERTIFICATE OF DEATH.

188-081

E 22720

1-PLACE OF DEATH Fish House Road Crossing.

City of BALTIMORE: (No. Westport St. 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tony Melnix.

(a) RESIDENCE NO. 129 W. Hamburg St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Track hand.

(b) General nature of industry, business, or establishment in which employed (or employer): W. Md. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Do not know.

14 Informant: Police Report. S. D.

(Address)

Filed ..... 19..... C. HAMPSON JONES, M. D.

1 - 1927 By R K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over and mangled by an Electric car of the U. S. & G. R. R. Co.
Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Bernhardt M. D.

(Coroner)

5/31 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russia Independent Sem. Date of Burial: June 1 1927

UNDERTAKER: John Grebbiuckse ADDRESS: 423 S. Paca St

(Spec.–7-17-26—A Co.—200 Bks.

E 22721

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22721

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1634 N. Bond St. 5-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Medora Passapae

(a) RESIDENCE NO. 1634 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Passapae

6 DATE OF BIRTH (month, day, and year): Oct 16-1849

7 AGE: 77 Years 78. Months 7 Days 14

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: John H. Worick

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Davis

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Joseph Passapae

(Address): 1634 N. Bond St

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

By .....

N 1 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to May 30, 1927

that I last saw her alive on May 30, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Danielson M. D.

, 19 (Address) 1714 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

Date of Burial: June 1st 1927

20 UNDERTAKER: Robt. J. Turner Inc.

ADDRESS: 1142 N. Broadway Balto. Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22722

CERTIFICATE OF DEATH.

E 22722
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 669 W. Barre ST. 27-30 WARD)

2-FULL NAME Mildred Hill

(a) RESIDENCE No. 669 W. Barre ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 13, 1926

7 AGE — Years: — Months: 9 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

PARENTS
9 BIRTHPLACE (city or town) Winsboro (State or country) South Carolina
10 NAME OF FATHER Edward Hill
11 BIRTHPLACE OF FATHER (city or town) Winsboro (State or country) South Carolina
12 MAIDEN NAME OF MOTHER Annie Waters
13 BIRTHPLACE OF MOTHER (city or town) Winsboro (State or country) South Carolina

14 Informant: Edward Hills
(Address) 669 W. Barre St.

Filed JUN 1 - 1927 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May - 30, 1927, to May - 31, 1927.
that I last saw her alive on May 30, 1927.
and that death occurred, on the date stated above, at 7.40 p. m.
The CAUSE OF DEATH* was as follows:
Acute Bronchopneumonia
Primary
(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? none
(Signed) D. W. Truslow M. D.
May 31 1927 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem.
20 UNDERTAKER: John H. Troadec

DATE OF BURIAL: Jun 2 1927
ADDRESS 10-27 Lanvale

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22723

CERTIFICATE OF DEATH.

E 22723

1-PLACE OF DEATH Franklin Sq. Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11-24 ST. (WARD)

2-FULL NAME Mrs Amy Tilghmann

(a) RESIDENCE No. 1117 Bolton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Thomas Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Emma Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Thomas Miles Jr 1117 Bolton St

15 Filed , 1927 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~February~~ April 2, 1921, to May 29, 1927, that I last saw h[illegible] alive on May 29, 1927, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis following Acute P I D.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W W Walker, M. D.

, 19 (Address) F. Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bare Hill. md

DATE OF BURIAL: June 1, 1927

20 UNDERTAKER: John H. Ivadunn

ADDRESS 1037 Bond St

Cor.—12-9-25—A Co.—200 Bks.

Miller

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22724

CERTIFICATE OF DEATH.

185 E 22724

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospital (Ward) 2-4

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Mueller

(a) RESIDENCE NO. 604 S. Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): May 5-1858

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	69 yrs.	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Common

(c) Name of employer: City Jail

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Mueller

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: John W. Leonard

(Address): 2833 Mayfield ave

Filed JUN 7- 1927 By C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Laceration & Scalp & shock from fall down stair step at his home accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

(Signed) Jones M. Denton, M. D. (Coroner)

May 31, 1927 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 604 S Washington

Former or usual residence 604 S Washington

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dunn, Carroll — Date of Burial: June 1 1927

20 UNDERTAKER: Jos. J. Kerrigan — ADDRESS: 156 N. Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22725

E 22725

CERTIFICATE OF DEATH.

Registered No. 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 North Castle St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Levcik

(a) Residence No. 1001 North Castle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Annie Levcik

6-DATE OF BIRTH (month, day and year): Feb 7. 1869

7-AGE: 58 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): City Water Department

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Bohemia

PARENTS.

10-NAME OF FATHER: James Levcik

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Bohemia

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Bohemia

14-

(Informant): Annie Levcik

(Address) 1001 North Castle Street

15-

Filed 6-1-1927

C. HAMILTON JONES, M. D.

Registrar.

Rec'd

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 1 1927

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19.. that I last saw h.. alive on ..... 19.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19.. (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill — DATE OF BURIAL: June 5 1927

20-UNDERTAKER: August Pasch — ADDRESS: 2906 Eastland Ave.

RJ

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22726

CERTIFICATE OF DEATH.

E 22726

Registered No. 16-22

1-PLACE OF DEATH

City of BALTIMORE: (No. 924 N. Stricker St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Jacobs

(a) Residence No. 924 N Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-29-27

7-AGE. ~~yrs.~~ mos. ds.

If LESS than 1 day, hrs. or 35 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Bernice Gray

11-BIRTHPLACE OF FATHER (city or town) Va (State or Country),

12-MAIDEN NAME OF MOTHER, Lillie Jacobs

13-BIRTHPLACE OF MOTHER (city or town) D. C. (State or Country),

14- (Informant)

(Address)

15- Filed ... 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-29-27

17- I HEREBY CERTIFY, That I attended deceased from 5-29, 1927, to 5-29, 1927, that I last saw h[illegible] alive on 5-29 1927 and that death occurred, on the date stated above, at 4[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eva F. Dodge M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. University of Md.

DATE OF BURIAL, ... 19...

20-UNDERTAKER

ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

E 22727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22727

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) (Ward) 22730

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Glasgow

(a) RESIDENCE NO. 616 S. Eutaw st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Glasgow

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Addler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 6-1-1927 C. HAMPSON JONES, M. D. Registrar

1407

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 19 27, to May 26, 19 27,

that I last saw him alive on May 26, 19 27,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pleurisy with effusion.

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Gallen, M. D.

5-26-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (3) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	May 31 19 27

20 UNDERTAKER Eastern 916 ADDRESS Penna Ave

UNIVERSITY OF MARYLAND

Spec.–7-17-26—A Co.—200 Bks.

Caltagerone

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22728

21-001

E 22728

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

City of BALTIMORE: (No. Caroline & Aliceon St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nunzio Caltagerone

(a) RESIDENCE NO. 1030 Hillen St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5 1920

7 AGE: Years 7 Months 4 Days 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Vincent Caltagerone

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Vincent Caltagerone

(Address) 1030 Hillen St

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

N 1 - 1927 Per RA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1- 27 19

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to June 1st, 1927, that I last saw him alive on June 1st, 1927, and that death occurred, on the data stated above, at 8059 m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? — Data of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Frank R. Di Paula, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

Date of Burial June 3 19 27

20 UNDERTAKER Frank Creighton

ADDRESS 1916 Orland

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22729

CERTIFICATE OF DEATH.

11-001

E 22729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Druid Hill Ave ST. 12-59 WARD)

2-FULL NAME James H. Moorehead

(a) RESIDENCE NO. 2232 Druid Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary E. Moorehead

6 DATE OF BIRTH (month, day, and year): June 10, 1876

7 AGE: Years 50 | Months 11 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stable man

(b) General nature of industry, business, or establishment in which employed (or employer): Horses.

(c) Name of employer: Walker Mt. Dairy.

9 BIRTHPLACE (city or town) (State or country): Danville Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Danville Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Mary E. Moorehead

(Address) 2232 Druid Hill Ave

15 Filed 1927, 19 Per R.K. Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 28, 1927, that I last saw him alive on May 28, 1927, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows: Bronchio Pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chl. M. D.

5/31, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: June 1, 1927

20 UNDERTAKER: James Hendley

ADDRESS 1918 Druid

Spec.—7-17-26—A Co.—200 Bks.

E 22730

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 22730

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital.

City of BALTIMORE: (No. 7-4 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Oldewurtel -

(a) RESIDENCE NO. 6 S Washington St. Ward 2

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Oldewurtel.

6 DATE OF BIRTH (month, day, and year) July 7th 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John Bauernfeind

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie Hoffman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Edward J. Oldewurtel

(Address) 6 S. Washington St.

15 Filed JUN 1 - 1927 C. HAMPSON JONES, M. D. Registrar

16 Recorded by KH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1927, to May 30 1927.

that I last saw h[illegible] alive on May 30 1927.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Strangulated Ventral Hernia.

(duration) yrs. mos 7 days.

CONTRIBUTORY (Secondary) Diabetes Mellitus } about 2 yrs

Bronco pneumonia (duration) yrs. mos 2 ds.

18 Where was disease contracted at Home

if not at place of death?

Did an operation precede death? yes Date of May 24/27

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis - Chemical - Pathology

(Signed) C. E. Thomas, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial June 2nd 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 4038 Wolfe

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22731

CERTIFICATE OF DEATH.

1927

REGISTERED NO. E 22731

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Richards

(a) RESIDENCE NO. 502 N Montford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21-1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General natnre of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER John Callela

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Callela

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Mrs. Mary Callela

(Address) 502 N Montford Ave

15 Filed May 31 1927 19 HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gunshot wound right Lung

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (secondary) Laceration Liver

(duration) yrs. mos. 4 ds.

May 31 1927 (Signed) Geo Clinton Wades M. D. (Coroner)

(Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial June 1 1927

20 UNDERTAKER Chas C. Miller & Son ADDRESS 2534 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22732

CERTIFICATE OF DEATH.

8 1 5

E 22732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Greenmount Ave ST.) 9-47 (WARD)

2-FULL NAME Rita Jane Watson

(a) RESIDENCE NO. 3701 Greenmount Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14y. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 1, 1911

7 AGE — Years: 15 — Months: 8 — Days: 29 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer): pd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo W. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Theresa Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. Geo W. Watson

(Address) 3701 Greenmount Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 30, 1927, that I last saw her alive on May 26, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation.

(Signed) E. T. Bouchelle, M. D.

5-31-1927 (Address) 210 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: June 2 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Greenmount Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22733

CERTIFICATE OF DEATH.

E 22733

1-PLACE OF DEATH

REGISTERED NO. 1668

CITY OF BALTIMORE: (No. 1419 Poplar Grove St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatora Marsiglia

(a) RESIDENCE. No. 1419 Poplar Grove St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dominick Marsiglia

6 DATE OF BIRTH (month, day, and year): June 10 1868

7 AGE: Years 58 Months 11 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Charles Carrigia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Dominick Marsiglia (Address) 1419 Poplar Grove

15 Filed 19 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1926, to May 31 —, 1927.

that I last saw her alive on May 29 —, 1927.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Gastric

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) Nicholas W Pinto, M. D.

May 31, 1927 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: June 3 1927

20 UNDERTAKER: W M Rowlson

ADDRESS 2237 N Mon St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22734

E 22734

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33[illegible] & Calvert St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Judge William Mohr.

(a) RESIDENCE NO. 2734 St. Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mrs. Wm Mohr.

6 DATE OF BIRTH (month, day, and year) June 4, 1865

7 AGE: Years 64 | Months 11 | Days 27 | IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Judge Appeal Tax Court

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm Mohr.

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Miss Whetman

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Charles A. Mohr

(Address) 1216 Hunsdermans Ave

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

Rec'r R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to May 31, 1927, that I last saw h[illegible] alive on May 31, 1927, and that death occurred, on the date stated above, at 2[illegible] P m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 30, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Hannah M. D.

, 19 (Address) Union Memorial Hospital 33[illegible] & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: June 2 1927

20 UNDERTAKER: John O'Mitchell & Geo Eulton Thiel

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22735

CERTIFICATE OF DEATH.

E 22735
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE. (No. West Post Towner. N. Bst St. 25-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dip Ramsay

(a) RESIDENCE NO. Cherry Hill West Post Md St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: Colored
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wm Savory
(Address) West Post & Cherry Hill

15 Filed JUN 1 - 1927 HAMPSON JONES, M. D.
By R. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
R. R. Accident
Multiple Fractures
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

May 30 1927 (signed) G. E. Yates, M. D. (Coroner) (Address) 143 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial June 1 1927

20 UNDERTAKER Dennis Easton ADDRESS 916 E. Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22736
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 V

E 22736
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 5127 Palmer Ave ST.) 27-56 (WARD)

2-FULL NAME Byron Warfield Willey

(a) RESIDENCE NO. 5127 Palmer Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys D. Willey

DATE OF BIRTH (month, day, and year) Sept 19 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. R. R. Co

BIRTHPLACE (city or town) (State or country) Madison Wis

10 NAME OF FATHER Wm Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs. Gladys D. Willey
(Address) 5127 Palmer Ave

Filed 1927 . 19 R H , Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-30, 1927, to 5-30, 1927, that I last saw him alive on 5/30, 1927, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examin

(Signed) W. D. Brogan, M. D.

5/31, 1927 (Address) 1928 N Gilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL June 1 1927

20 UNDERTAKER Wm J. Tickner & Sons — ADDRESS N York Pa

Spec.—1-12-23—M&T—500 Blks.

22737 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22737

CERTIFICATE OF DEATH. 49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (N) W. Balto Gen Hosp (St.) 16-68 (Ward)

2-FULL NAME Mrs. Anna K. Ott

(a) RESIDENCE NO. W. Side Harford Rd near Joppa road (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: August G. Ott

7 DATE OF BIRTH (month, day, and year): Nov. 6, 1859

8 AGE: 67 Years 6 Months 25 Days If LESS than 1 day, hrs. or min.

68

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

11 NAME OF FATHER: Jacob Landerback

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Miss Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Aug. G. Ott

(Address) 300 E Edmondson Ave

Filed — 1927 C. HAMPSON JONES, M. D. Registrar

By: R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to May 31, 1927, that I last saw h alive on May 31, 1927 and that death occurred, on the date stated above, at 3:10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas (duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 2 yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/28/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Arnold Jacobs M. D.

5/31, 1927 (Address) Wm Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: June 3 1927

20 UNDERTAKER: John Mencke

ADDRESS: 2008 Orleans

Spec.—12-9-25—A (5)—200 Bks.

E 22738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 22733

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS 8-16

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mason or Martin Gragg

(a) RESIDENCE NO. 1751 E. Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
47	47	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Shucker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Fred. Mason

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

Filed JUN 1 - 1927 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/ 1927

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1927, to May 31, 1927

that I last saw him alive on May 31, 1927

and that death occurred, on the date stated above, at 12.10 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) C. Sullivan Gant M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. Date of Burial: June 3 1927

20 UNDERTAKER: John Ulrich ADDRESS: 220 E. Eden

Spec.–7-17-26—A Co.—200 Bks.

Crew.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22739

11 E 22739

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. ..... St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Crews

(a) RESIDENCE NO. 106 S. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Crews

6 DATE OF BIRTH (month, day, and year): Aug. 24 1862

7 AGE: 64 Years 6 Months 4 Days 6 — IF LESS than 1 day ..... hrs. or ..... min..

65 10 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER: Luther Akins

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Balto.

12 MAIDEN NAME OF MOTHER: Matheson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto.

14 Informant: Hospital Record.

(Address) C. HAMPSON JONES, M. D.

15 Filed JUN 1 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/23 1927, to 5/30 1927, that I last saw h.r alive on 5/30 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

Ovarian tumor

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis - cardiac failure (duration) yrs. mos. 4 days

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 4/29/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Stamps M. D.

. 19 (Address) 1 W Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: June 1 1927

20 UNDERTAKER: Harry M Wolfe — ADDRESS: 15 W Mulberry

Cor.—12-9-25—A Co.—200 Bks.

(Pzybylaki)

HEALTH DEPARTMENT, CITY OF BALTIMORE

E 22740

CERTIFICATE OF DEATH.

182 E 22740

REGISTERED NO.

1-PLACE OF DEATH Found in Harbor

City of BALTIMORE: (No. Fort Kenwood ave., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Pzybylaki

(a) RESIDENCE NO. 110 S Kenwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1901

7 AGE: Years 25 Months 8 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Joseph Pzybylaki

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Segehowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Joseph Pzybylaki

(Address) 110 S Kenwood

Filed MAY 31 - 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(missing Fri May 24 1927)

(duration) 6 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Kenton M. D. (Coroner)

5/31 1927 (Address) 7002 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Date of Burial June 2 1927

UNDERTAKER Stephen Filkowski ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 E 22741

E-22741 DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1404 N. Eutaw ST. 15-21 WARD)

2-FULL NAME Mrs. Pinkie Rains Worley

(a) RESIDENCE NO. 1404 N. Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Worley

6 DATE OF BIRTH (month, day, and year) Aug 7th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wakefield Surry Co. Va

PARENTS

10 NAME OF FATHER James Rains

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mahoodeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs. Lillian Lineburn, Essex Va

15 Filed 1-1927 19 C. HAMPSON JONES, M. D. Registrar

Per BM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1927, to May 31st, 1927.

that I last saw her alive on May 31st, 1927

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute Septic Endocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Jaundice

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) A. Reilly M. D.

6-1, 1927 (Address) 710 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Va

DATE OF BURIAL June 1 19 27

20 UNDERTAKER Wm. H. Crawford

ADDRESS Wakefield Va

Spec.—12-9-25—A Co.—200 Bks.

E 22742

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 E 22742

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 10-14 Ward)

2-FULL NAME Beverly Sittman

(a) RESIDENCE NO. 1408 E Biddle St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 1, 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
2	2½	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ND

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country) Md

PARENTS

10 NAME OF FATHER Abraham Sittman

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Sapasky

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balt St

15 Filed ___ 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6-1-27

17

I HEREBY CERTIFY, That I attended deceased from 5-31, 19 27, to 6-1, 19 27

that I last saw her alive on 6-1, 19 27

and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Encephalitis (?)

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of ___

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M H Rumpfield, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — Date of Burial 6/ 19 27

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

Spec.—12-9-25—A Co.—200 Bks. See Letter on file from R.T. Smith MD dated 6-9-27

HEALTH DEPARTMENT—CITY OF BALTIMORE

22743

CERTIFICATE OF DEATH.

90 E 22743

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 157-48

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Barnham

(a) RESIDENCE NO. 100 Center Cove St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ~~1854~~ 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
58 yrs	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER David Barnham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Clarissa —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant CITY HOSPITALS

(Address) [redacted] Woods

15 Filed [illegible] 1927 HAMILTON JONES M.D. Registrar

1409 RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1927

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to May 26, 1927, that I last saw him alive on May 26, 1927, and that death occurred, on the date stated above, at 11 25 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy.

Myocardial insufficiency

Gangrene both feet

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gunual & laboratory

(Signed) R Hooper Smith, M. D.

May 27 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, [redacted] from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 22744

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 N. Fulton Ave ST. 16-22 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Louisa Mitchell

(a) RESIDENCE NO. 735 N. Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas A. Mitchell

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 63; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rachael Bromley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Pa.

14 Informant: Evelyn Beyer

(Address): 735 N. Fulton Ave

15 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927 to May 31 1927, that I last saw her alive on May 31 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horace G. Todd M. D.

6/1/27 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 6/2 1927

UNDERTAKER: Chas. F. Mauldin

ADDRESS: 1180 W. Baltimore St.

Spec.—12-9-25—A Co.—200 Bks.

E 22745

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 2 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hirsch Cherry

(a) RESIDENCE NO. 1713 E. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Cherry

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 67 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER David Cherry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Harris Cardan

(Address) 1713 E Baltimore St

15 Filed 1927

Registrar RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-1- 27

17 I HEREBY CERTIFY, That I attended deceased from 5-27, 19 27, to 6-1, 19 27

that I last saw h(e) alive on 6-1, 19 27,

and that death occurred, on the date stated above, at 10 (a.m.) p.m.

The CAUSE OF DEATH* was as follows:

Acute hypostatic Pneumonia (Primary)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Signs —

(Signed) A. Victor Robin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

North Point Cemetery 6/1 1927

20 UNDERTAKER ADDRESS

Jack Levin 1439 E Balto St

Cor.—12-9-25—A Co.—200 Bks.

E 22746

HEALTH DEPARTMENT—CITY OF BALTIMORE

199 E 22746

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St., 3-4 Ward)

2-FULL NAME Lillian Cituk.

(a) RESIDENCE NO. 248 S. Caroline St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, (or) WIFE of Peter Cituk.

6 DATE OF BIRTH (month, day, and year) March 28, 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker

(b) General nature of indusiry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Chicago Ill.

PARENTS

10 NAME OF FATHER Joseph Kalinowski.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Frances Rykaczewski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Frances Rykaczewski. (mother)

(Address) 51b S. Bond St.

15 1927 G. HAMPSON JONES, M. D.

By _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Incomplete self induced Miscarriage

Anaemia.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

(Signed) Thos. M. Steinhart M. D. (Coroner)

5/1 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

234 E. Caroline St. May 5, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial June 2 1927

20 UNDERTAKER J. H. Ozazlewski ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 22747

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22747

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 Gantley ST., 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. O'Neill

(a) RESIDENCE NO. 747 Gantley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael O'Neill

6 DATE OF BIRTH (month, day, and year) Jan 19, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER [illegible] Welsh.

11 BIRTHPLACE OF FATHER (city or town) Ireland.

(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Unknown.

(State or country)

14 Informant Louis O'Neill

(Address) 747 Gantley St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927.

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1927. to June 1, 1927.

that I last saw h[illegible] alive on May 31, 1927.

and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Lorgan Wade M. D.

1927 (Address) 1000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Prince Geo. Co. Md) St. Mary's Cem.

DATE OF BURIAL June 4 1927.

20 UNDERTAKER Easter Son

ADDRESS Ellicott City

Spec.—1-10-21—M&T—1500 Bks.

E 22748

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 559 S. Longwood ST. 20 WARD 1)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Frances Tucker.

(a) RESIDENCE NO. 559 S. Longwood. ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Allen C. Tucker

6 DATE OF BIRTH (month, day, and year): [illegible] 7, 1865

7 AGE — Years: 61 — Months: 9 — Days: 23 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: [illegible] Wideman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Allen C. Tucker

(Address): Same as 15

15 Filed [illegible], 1927 Reg'd [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to May 31, 1927.

that I last saw her alive on May 31, 1927.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical evidence & Physical signs

(Signed) Jos L. Zeigler M. D.

Jun 2 1927 (Address) 1123 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: June 3, 1927.

20 UNDERTAKER: Hound Co. Easton Md.

ADDRESS: Ellicott City

Spec.—7-17-26—A Co.—200 Bks.

Dr D Miller 1500 N Broadway

E 22749

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 22749

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1923 N. Collington Ave St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie V. Ozman

(a) RESIDENCE NO. 1923 N. Collington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry C Ozman

6 DATE OF BIRTH (month, day, and year): Nov 9, 1857

7 AGE: Years 69 Months 6 Days 22

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph North

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Rhonda Davis

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Harry C Ozman

(Address) 1923 N Collington Ave

15 Filed: C. HAMPSON JONES, M. D.

1927 By: RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 31, 1927.

that I last saw h[illegible] alive on May 31, 1927.

and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 2- ds.

CONTRIBUTORY (Secondary) Acute Glomerular Nephritis

(duration) yrs. 3- mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Attending

(Signed) Dr. Paul Miller, M. D.

6/1, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: June 3 1927

20 UNDERTAKER: [illegible] — ADDRESS: 502 E Monument

Spec.–7-17-26—A Co.—200 Bks.

E 22750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90 E 22750

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2020 Clifton Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Williams

(a) RESIDENCE NO. 2020 Clifton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelius F

6 DATE OF BIRTH (month, day, and year): July 25 1859

7 AGE — Years: 67 Months: 10 Days: 6

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: James Anderson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Cornelius Williams

(Address): 2020 Clifton Ave

15 Filed: 1927 C. HAMPSON JONES M. D. Registrar

Per: RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: May 31st

17 I HEREBY CERTIFY, That I attended deceased from 5/26, 19 27 to 5/31, 19 27

that I last saw h[illegible] alive on 5/31, 19 27

and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows: Calculous Heart Disease

(duration) 10 yrs. 2 mos. 6 da.

CONTRIBUTORY (Secondary): Diabetes Edema of Lung

(duration) 2 yrs. 8 mos. 6 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Henry H. Cowell M. D.

6/4, 1927 (Address) Upland Rd

State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: 6/4 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 503 E-N Ave

Spec.–7-17-26—A Co.—200 Bks.

Bauden 1517 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22751

CERTIFICATE OF DEATH

90 E 22751

REGISTERED NO. 9-46

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 Belmont St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Weisman

(a) RESIDENCE NO. 1308 Belmont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Weisman

6 DATE OF BIRTH (month, day, and year) August 9- 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	47	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis C. Berger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Portland Maine

12 MAIDEN NAME OF MOTHER Katherine Krausz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Chas E Weisman

(Address) 1308 Belmont Ave

15 1927 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 1927 to May 29 1927

that I last saw h.. alive on May 29 1927

and that death occurred, on the date stated above, at 9 20 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY Acute cardiac

(Secondary)

dilatation (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George Alvey Bauden M. D.

5/30 1927. (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial 6/2 1927

20 UNDERTAKER Jos Cook

ADDRESS 501 E Mad

Dr John Bishop 9300 Calvert

Spec.--7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22752

CERTIFICATE OF DEATH

47

E 22752

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 702 Bartlett Ave 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Galligan

(a) RESIDENCE NO. 702 Bartlett Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1853

7 AGE Years: 74 Months: 4 Days: 1 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Alexander Galligan

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florilla Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Rath

(Address) 1224 E Fountain St

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1927, to May 31 1927, that I last saw him alive on May 31 1927, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 1923

Was there an autopsy? No

What test confirmed diagnosis? clin. diagn.

(Signed) Glenn S. Richter, M. D.

1927 (Address) 930 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: June 3 1927

20 UNDERTAKER: Wm Bach — ADDRESS: 502 E Monument

C. HARRISON JONES M. D.

1927

RHW

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22753

CERTIFICATE OF DEATH.

90 E 22753

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2939 Hait Ave St., 1st Ward)

2-FULL NAME Sarah F. Hoover

(a) RESIDENCE NO. 2939 Hait Ave St. 1st Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Hoover

6 DATE OF BIRTH (month, day, and year) Oct 7, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	7	23	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Hilgastuck

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country) Germany

14 Informant May Hoover

(Address) 2939 Hait Ave

15 Filed 1927 H. L. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 30, 1927, that I last saw her alive on May 29, 1927 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy (fatty degeneration)

(duration) for several years yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

Syncope (duration) yrs. mos. about 3 weeks

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 1927 (Address) 1014 S. Belnord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: June 2 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22754

CERTIFICATE OF DEATH.

129 E 22754

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. St. 10-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina E. Flaherty

(a) RESIDENCE NO. 1241 E. Madison St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 2 1911

7 AGE: Years 16 yrs | Months 2 | Days 28 | IF LESS than 1 day ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Ernest Flaherty

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Bessie Roffey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant: Johns Hopkins Hospital Records

(Address)

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1926 to May 30, 1927

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter Athey, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial 6/2 1927

20 UNDERTAKER: Liston V. Russellaugh — ADDRESS 2620 St Paul

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22755

E 22755

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1452 Stevenson St. 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Gricht

(a) RESIDENCE NO. 1452 Stevenson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 22, 1913.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	13	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER John Gricht

11 BIRTHPLACE OF FATHER (City or town) Hungary

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Lois

13 BIRTHPLACE OF MOTHER (city or town) Hungary

(State or country)

14 Informant Catherine Lois

(Address) 1452 Stevenson Ave

15 Filed JUN 2 - 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 23 19 27 to May 30 19 27

that I last saw h[illegible] alive on May 29 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Decompensated

(duration) yrs. mos. 8 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos F. Stevens M. D.

6-1- 19 27 (Address) 2878 Huntington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Margaret B. Flynn

20 UNDERTAKER London Park

Date of Burial June 1 19 27

ADDRESS 1452 Stevenson

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22756

E 22756

1145

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 855 Vine St. 18-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Patterson

(a) RESIDENCE NO. 855 Vine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Wid

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 65 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mary Howe

(Address) 855 Vine St.

15 Filed 2-1927, 19 HAMP. JONES, M. D. Registrar R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 30, 1927,

that I last saw h..... alive on May 30, 1927,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Norwood, M. D.

(Address) 855 or Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: June 2, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS: 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22757

CERTIFICATE OF DEATH.

49

E 22757

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Edmondson Ave St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Kirwan

(a) RESIDENCE NO. 1806 Edmondson Ave St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ida May Kirwan

DATE OF BIRTH (month, day, and year) Feb. 11 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	18 20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Cadillac Co

BIRTHPLACE (city or town) Balto.

(State or country) Md.

10 NAME OF FATHER William Kirwan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Esther ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

Informant Mr. Chas. Kirwan

(Address) 4312 Copland Ave.

Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3 1927 to May 31 1927

that I last saw h[illegible] alive on May [illegible] 1927

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the urgnt -

Hemmedicall Cause - Exhaustion

(duration) 0 yrs. - mos ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Franklin Sq

Did an operation precede death? Date of May 4, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] H. Reik M. D.

19 (Address) 1102 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 2 1927
20 UNDERTAKER	ADDRESS
Wm Flickner Sons	North Ave

2-1927 HAMPSON JONES, M. D.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22758

CERTIFICATE OF DEATH.

E 22758

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1821 Bolton St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Pryor

(a) Residence No. 1821 Bolton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H Pryor

6-DATE OF BIRTH (month, day and year) 1/25/56

7-AGE 71 yrs. 4 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, John Allard

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Thomas

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country),

14- (Informant) Mrs. Mamie E Pryor

(Address) 1821 Bolton St

15- JUN 2 - 1927 Registrar. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31/27

17- I HEREBY CERTIFY, That I attended deceased from May 31, 1927 to May 31, 1927

that I last saw her alive on May 31, 1927

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. E. Krafft M. D.

6/2, 1927 (Address) 1002 N. Laurens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Park Cem

DATE OF BURIAL June 2, 1927

20-UNDERTAKER. D. F. Fisher & Sons

ADDRESS Hosp

Spec.—1-12-23—M&T—500 Blks.

22759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 J

E 22759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 S Charles ST. 23-32 WARD)

2-FULL NAME Margaret E Schwartzrow

(a) RESIDENCE NO. 1824 S Charles ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: J. D. Schwartzrow

DATE OF BIRTH (month, day, and year): Jany 14-1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto Co

10 NAME OF FATHER: Edward Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: J. D. Schwartzrow

(Address) 1824 Charles

Filed 2 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to June 1, 1927

that I last saw h— alive on May 31, 1927

and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. H. Campbell, M. D.

June 1, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 3 1927
20 UNDERTAKER	ADDRESS
W. T. Hudson Sons	Balto

Spec.—12-9-25—A Co.—200 Bks.

Elaine Clark

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22760

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

E 22760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 3-4 Ward)

2-FULL NAME Elaine Clark

(a) RESIDENCE NO. 901 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 11-18-1926

7 AGE: Years ____ Months 6 Days 13 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER David Clark

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER Viola Bracombe

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

Filed 6 2 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1927, to May 31, 1927, that I last saw h.. alive on May 31, 1927, and that death occurred, on the date stated above, at 5:40 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) ____ yrs. ____ mos. 14 ds.

CONTRIBITORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial 6-2 1927

20 UNDERTAKER: Mrs Chas G Bailey — ADDRESS 1721 Jefferson St

Leslie W Agnew.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

203 280 E 22761

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

137 E 22761

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 79 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie W. Agnew

(a) RESIDENCE NO. 1583 Lee St. Charleston St. W. Va Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Cavender

6 DATE OF BIRTH (month, day, and year) Feb 7. 1886

7 AGE Years	Months	Days 24	IF LESS than 1 day ....hrs. or ....min.
41	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) Ky

(State or country)

PARENTS

10 NAME OF FATHER Samuel A. Agnew

11 BIRTHPLACE OF FATHER (city or town) Ky

(State or country)

12 MAIDEN NAME OF MOTHER Sarah L. Pugh

13 BIRTHPLACE OF MOTHER (city or town) Ky.

(State or country)

14 Informant (Address) Johns Hopkins Hospital

15 Filed 6-2 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23 1927, to June 1 1927, that I last saw him alive on June 1 1927, and that death occurred, on the date stated above, at 3 32 p m.

The CAUSE OF DEATH* was as follows:

Hydronephrosis R.

Ureteral stricture R.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Patient

Did an operation precede death? yes Date of May 25 27

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) Robert Wilkinson, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston W. Va Date of Burial June 2 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

E 22762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22762

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Hollins ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M Litz

(a) RESIDENCE NO. 922 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Edith S. Litz

6 DATE OF BIRTH (month, day, and year) May 12, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	-	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Litz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Edith S. Litz

(Address) 922 Hollins St.

15 Filed NOV 2 - 1927

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20. 1927, to May. 31st 1927.

that I last saw h alive on May. 31. 1927.

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 1 yrs. \ mos. \ ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) \ yrs. 6 mos. \ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) Thaelsorton M. D.

6/1/27 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 6/4/1927

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St.

004

Spec.-7-17-26—A Co.—200 Bks.

E 22763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 22763

1-PLACE OF DEATH

REGISTERED NO. 8-40

City of BALTIMORE: (No. 3105 Cliftmont Ave. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Freedenburg,

(a) RESIDENCE NO. 3105 Cliftmont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Freedenburg,

6 DATE OF BIRTH (month, day, and year) January 28, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
63	62	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Sergeant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. Freedenburg,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Lang.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Clara Freedenburg

(Address) 3105 Cliftmont Ave.

15 Filed JUN 2 - 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 1 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1925, to June 1, 1927, that I last saw h[e] alive on May 31, 1927, and that death occurred, on the date stated above at m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Brunn M. D.

6/2/27 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial JUN 4 - 1927

20 UNDERTAKER Geo W Little

ADDRESS 2708 EDMONDSON AVE.

Spec.—12-9-25—4 Co.—200 Bks.

2.02956

101-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 22764 JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 5[illegible]6 St. Ward)

2-FULL NAME Hilda Gennett

(a) RESIDENCE NO. 524 McElderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 27 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Gennett

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Ruth Lindell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL

(Address) C. HAMILTON JONES, M. D.

15 Filed JUN 2 1927 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 31-1927

17

I HEREBY CERTIFY, That I attended deceased from May 12, 19 27, to May 31, 19 27

that I last saw h[illegible] alive on May 31, 19 27

and that death occurred, on the date stated above, at 1[illegible]45 Am.

The CAUSE OF DEATH* was as follows:

Primary lobar pneumonia, endocarditis, peritonitis.

(duration) yrs. mos. 26 ds.

CONTRIBITORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) T. Ridgeway Trimble, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Date of Burial: 6/3 19 27

20 UNDERTAKER: Byrnes & Wright ADDRESS 218 McElderry St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22765

CERTIFICATE OF DEATH.

38 E 22765

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 8-12 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Carter

(a) RESIDENCE NO. 1113 N. Carrollton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas C. Carter.

6 DATE OF BIRTH (month, day, and year) July 4, 1872

7 AGE Years 54 yrs Months 10 Days 26 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Va

PARENTS

10 NAME OF FATHER Thomas Robatson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Belle Taylor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Silas C. Carter

(Address) 1113 n. Carrollton ave

15 Filed 6-2 1927 C. HAMPSON JONES, M. D. Registrar

By R M C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1927, to 5/30, 1927, that I last saw h alive on 5/30, 1927, and that death occurred, on the date stated above, at 6:20 p. m.

The CAUSE OF DEATH* was as follows: Carcinomatosis Lues —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Augusta, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL June 2 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22766

CERTIFICATE OF DEATH.

90

E 22766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Windsor Ave ST. 15-61 WARD)

2-FULL NAME Mr George H. Elmer

(a) RESIDENCE NO. 3302 Windsor Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta L. Elmer.

6 DATE OF BIRTH (month, day, and year): Dec 2 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa.

PARENTS

10 NAME OF FATHER: Lewis Elmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Goshen N.Y. Penna.

12 MAIDEN NAME OF MOTHER: Mary A. Huskenham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa. " "

14 Informant (Address): Mrs Mary E. Kennard (Niece) 3922 Harford Road

15 Filed JUN 2 - 1927 by C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to June 1, 1927, that I last saw h alive on June 1, 1927, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows: Malignant Endocarditis

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A. Kraus, M. D.

1927 Address 612 N 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 3rd 1927

20 UNDERTAKER: Latham & Hoe

ADDRESS: 1723 W. Lafayette Ave

Cor.—12-9-25—A Co.—200 Bks.

E 22767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002

E 22767

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Johnson

(a) RESIDENCE NO. 203 S. Spring St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Water

(c) Name of employer Dept.

9 BIRTHPLACE (city or town)

(State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER -------Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wash., D.C.

12 MAIDEN NAME OF MOTHER Rachel----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Charlotte, S.C.

14 Informant Dippel (undertaker)

(Address)

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per R.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 May 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull (occiput)

Struck by street car at Pratt & Caroline Sts.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Walter (Coroner) M. D.

6/3/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion — Date of Burial May 2 1927

20 UNDERTAKER Wendell L. Dippel — ADDRESS 300 E. Lee

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22768

CERTIFICATE OF DEATH.

22-31 1827

REGISTERED NO. E 22768

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Henry & York Sts. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sylvester Battle.(C)

(a) RESIDENCE NO. 127 W. Hill St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 4, 1917.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Battle.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Clara Cook.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Mamie Cook.(grandmother)

(Address) 127 W. Hill St.

15 Filed JUN 2 1927 by H. HAMPSON JONES, M. D. Registrar

For K. H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1917

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Occidental fall into the water while on a wharf.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner)

6/1 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs., ...mos., ...ds. In the State....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial June 3 19 27

20 UNDERTAKER C. A. Brown & Son ADDRESS Mt. Auburn

Spec.–7-17-26—A Co.—200 Bks.

E 22769

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22769

CERTIFICATE OF DEATH

31 V

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals S.F.T. 22730 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) RESIDENCE NO. 606 Comb Alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) O'K

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Turner Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

JUN 2 - 1927

Filed HAMPTON JONES M. D. Registrar

Per RA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 19 27, to May 28, 19 27,

that I last saw him alive on May 28, 19 27,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Data of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) W. E. Gallehugh, M. D.

5-28-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shellman's New, Kent Co Va

Date of Burial June 3 19 27

20 UNDERTAKER J. E. Brown's Son

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 22770

CERTIFICATE OF DEATH.

E 22770 PLACE OF DEATH

25-73 90 REGISTERED NO.

CITY OF BALTIMORE: (No. Hollins Ferry Road ST. Lakeland WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Foerster

(a) RESIDENCE NO. Hollins Ferry Road Lakeland WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Foerster

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired about 2 years.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Foerster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Ditmman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to June 1, 1927, that I last saw h[illegible] alive on May 31, 1927 and that death occurred, on the date stated above, at 2.05 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. Mitchell M. D.

June 1, 27 (Address) 232 N. Bel. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Mr. John A. Foerster Hollines Ferry Road Lakeland

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL June 3 1927

20 UNDERTAKER Nelson E. Stiles ADDRESS 231 Md Ave Westport

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

Spec.—12-9-25—A Co.—200 Bks.

E 22771

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22771

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St. 18-26 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McCall (Bernard)

(a) RESIDENCE NO. 819 Belmondsay Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
May 20 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard McCall.

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUN 2 1927 G. HAMPSON JONES, M. D. Registrar

1927 1414

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
May 28 1927

17
I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to May 28, 1927, that I last saw h.. alive on May 28, 1927, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Atresia pancreatorum

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death? at home - (?)

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. D. Price, M. D.

, 19 (Address) Johns Hopkins Hosp —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

JUN 2 1927
Commissioner Health

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22772

E 22772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. St. 13-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Stults

(a) RESIDENCE NO. 33rd + Chestnut Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 30-1927

7 AGE: Years | Months 4 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER — — —

11 BIRTHPLACE OF FATHER (city or town):

(State or country) — —

12 MAIDEN NAME OF MOTHER Virginia Stults

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) U.S.A.

14 Informant: JOHNS HOPKINS HOSPITAL

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D.

Per 1412 CHB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 31-1927

17

I HEREBY CERTIFY, That I attended deceased from May 9, 19 27, to May 31, 19 27,

that I last saw h[illegible] alive on May 31, 19 27

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Mal nutrition (with Terminal pneumonia) Malnutrition since birth (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diets medic. (duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

JUN 2 1927 Commissioner of Health

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22773

CERTIFICATE OF DEATH.

E 22773

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 Bayonne Ave St. Hamilton Ward 43

2-FULL NAME Gustave A. Gleichmann

(a) RESIDENCE NO. 30 Bayonne Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Minna Gleichmann

6 DATE OF BIRTH (month, day, and year): Nov. 13-1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Piano Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: Adam Gleichmann

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Minna Gleichmann

(Address): 30 Bayonne Ave

15 Filed: 1927 By: G. HAMPSON JONES, M. D. Registrar

Per: RRS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from March 16th 1927, to June 1st 1927, that I last saw him alive on May 31st 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH*, was as follows:

Gastric Epithelioma (Pylorus).

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dallas B. A. Megee, M. D.

June 2, 1927 (Address) 1037 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial June 4 1927

20 UNDERTAKER: Mrs. Wm. H. Taylor & Son ADDRESS 811 E. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22774

E 22774

CERTIFICATE OF DEATH.

23-33 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Patapsco ST.) (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth E. Hecker

(a) RESIDENCE No. 1225 Patapsco ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1. 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) Eastern High

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Hecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Myrtle Kinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Henry Hecker

(Address) 1225 Patapsco St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

16 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1927, to May 31, 1927,

that I last saw h alive on May 30, 1927,

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis.

(duration) yrs. 3 mos. 28 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) James R. Hampson Jones, M. D.

6/1, 1927 (Address) 1729 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 3 1927

20 UNDERTAKER Mrs. J. W. Leufelt & Son — ADDRESS 801 W. Fayette

Spec.—12-9-25—A Co.—200 Bks.

E 22775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St., 7 Ward)

2-FULL NAME William Venable

(a) RESIDENCE NO. 623 N Dallas St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Va.

PARENTS

10 NAME OF FATHER Archie Venable

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Minnie Venable

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Woods

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to May 30, 1927, that I last saw h. alive on May 30, 1927, and that death occurred, on the date stated above, at 9 1/4 m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of liver

(duration) ___ yrs. ? mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? ___ Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hopkin Smith M. D.

, 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial June 2 1927

20 UNDERTAKER Edward Bryan ADDRESS 1051 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

22776

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ E 22776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2152 Woodbrry Ave. St., 13-57 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Gephardt

(a) RESIDENCE NO. 2152 Woodbrry Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Geo. Gephardt

6 DATE OF BIRTH (month, day, and year): Dec 2nd 1859

7 AGE — Years: 67 | Months: 5 | Days: 28 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Germany

10 NAME OF FATHER: ~~Not Known~~ Geigner

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: ~~Not Known~~

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

PARENTS

14 Informant (Address): John G. Gephardt 2152 Woodbrry Ave.

15 Filed 5-31 1927 Registrar WPA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from October 1 1925 to May 30 1927, that I last saw h.er alive on May 30 1927, and that death occurred, on the date stated above, at 1st p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 1 8 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Davies, M. D.

5-31-1927 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: 6/3 1927

20 UNDERTAKER: E. C. Fenning & Son — ADDRESS: 1938 E. Lafayette ave.

Spec.—12-9-25—A Co.—200 Bks.

E 22777 E 22777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

203 1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 27-55 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Vance

(a) RESIDENCE NO. 5310 Dennore Ave, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 3-4-26

7 AGE: Years 1 | Months 2 | Days 26 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: William Vance

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Ely

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant (Address): Johns Hopkins Hospital

C. HAMPSON JONES, M. D.

15 Filed 1927, 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to June 1, 1927, that I last saw h[illegible] alive on June 1, 1927, and that death occurred, on the date stated above, at 12:45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (If not at place of death) Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H A Price, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Dr. Charles Simms 3 1927

20 UNDERTAKER: Thanowetheon ADDRESS 3615 Chestnut

Spec.-7-17-26—A Co.—200 Bks.

E 22778

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22778

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 3-5-57

City of BALTIMORE: (No. 818 Union Ave St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella B. Fisher

(a) RESIDENCE NO. 818 Union Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Fisher

6 DATE OF BIRTH (month, day, and year) Nov 11, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER George Cornbower

11 BIRTHPLACE OF FATHER (City or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Liddie Cornbower

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant James H. Fisher

(Address) 818 Union Ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D.

1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1926, to June 1st, 1927.

that I last saw her alive on May 31, 1927

and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jerome Driller M. D.

6/1, 19 27 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

Date of Burial June 3, 19 27

20 UNDERTAKER Thanhouser Son

ADDRESS 3615 Keswick Ave

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 22779

HEALTH DEPARTMENT—CITY OF BALTIMORE

184-003

CERTIFICATE OF DEATH.

E 22779

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospotal St. 27-43 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James William McQuaide

(a) RESIDENCE NO. 11 E. Glenmore Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Feb 23/24

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank J. McQuaide

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Marie Mavers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Frank J. Mcquaide

(Address)

15 Filed 6-1-1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hem. Fractured skull
Struck by automobile at 11 E
glenmore ave

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) [signature], M. D.
(Coroner)

6/1/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn Cemetery Date of Burial June 3 1927

20 UNDERTAKER Robt J Turner ADDRESS 2403 E. Broadway

Spec.—1-10-21—M&T—1500 Bks.

Knof

E 22780

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N Amity ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Knopf

(a) RESIDENCE No. 203 N Amity ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26 1890

7 AGE: Years 36 Months 10 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator

(b) General nature of industry, business, or establishment in which employed (or employer) Operater

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER James Knopf

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Knopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James Knopf (Address) 203 N Amity

15 Filed 6-2 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1927, to June 1, 1927, that I last saw h[illegible] alive on May 31, 1927, and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

6/2 1927 (Address) 108 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 3 1927

20 UNDERTAKER: George J Smith — ADDRESS: [illegible]

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22781

CERTIFICATE OF DEATH.

46 ✓

E 22781

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

2-FULL NAME Annie Hurley

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 67

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Hurley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed 1927 HAWKINS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from

No record, 19..., to ..., 19...,

that I last saw h..... alive on ..., 19...,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) senile

Marasmus (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

June 2, 1927 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial June 3, 1927

20 UNDERTAKER Rita Mackfield ADDRESS 714 Fremont Ave

Spec.—1-12-23—M&T—560 Bks.

E 22782 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1823 Wilkens Ave., ST. 19-28 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Schneider

(a) RESIDENCE NO. 1823 Wilkens Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Christina (nee Weber)

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher.

(b) General nature of Industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Mathew Schneider.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary,

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christina Schneider

(Address) 1823 Wilkens Ave.

15 Filed 6-2-1927 C. HAMPSON JONES, M. D. By RKW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1926, to May 31, 1927, that I last saw h[illegible] alive on May 30, 1927 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

Hypertension

Chronic Interstitial Nephritis

(duration) 1 yrs. + mos ds.

CONTRIBUTORY (Secondary) Ad. Dil. of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. G. Harz, M. D.

6-2-1927 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mier Cathedral Cemetery DATE OF BURIAL June 3 1927

20 UNDERTAKER Harry H Weitzke ADDRESS 1531 N Fremont

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 22783

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2626 Guilford Ave St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edwin Wrightson

(a) Residence No. 2626 Guilford Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-If married, widowed or divorced (Write the word.): Married

5a-If married, widowed or divorced HUSBAND of (or WIFE of) Katie L. Wrightson

6-DATE OF BIRTH (month, day and year) Nov. 26. 1874

7-AGE. 52 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerical

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel business

(c) Name of employer: Rennert Hotel Co.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas S. Wrightson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary J. Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs Katie Wrightson (wife)
(Address) 2626 Guilford Ave

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 1. 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1925 to June 1 1927 that I last saw h alive on June 1 1927 and that death occurred, on the date stated above, at 6:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leo Keller M. D.

, 19 (Address) 1927 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Louden Park Cemetery

DATE OF BURIAL. June 4. 1927

20-UNDERTAKER. Myles & Brady Inc.

ADDRESS 424 N. Broadway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22784

CERTIFICATE OF DEATH.

112 E 22784

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 546 So. Paca St. 22-30 Ward)

2-FULL NAME Rosie A. Weller

(a) RESIDENCE NO. 546 So Paca St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Weller

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 48 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto

PARENTS

10 NAME OF FATHER: Sam'l Braon

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto, Md

14 Informant: Harry Weller

(Address): 546 So. Paca St

15 Filed _____, 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and from autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) 15 Min yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Thos. B. Horton M. D.

June 2nd 1927 (Address) Curtis Bay, Balto, Md

(Coroner)

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Date of Burial June 4 1927

20 UNDERTAKER: Wm Cook ADDRESS 502 E Lombard

Cor.—12-9-25—A Co.—200 Bks.

22785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22785

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2808 N. Calvert St. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Horn.

(a) RESIDENCE NO. 2808 N. Calvert St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of (XXXXXXX) Margaret K. Horn.

6 DATE OF BIRTH (month, day, and year) June 30, 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Horn.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Frances -------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Margaret K. Horn. (wife)

(Address) 2808 N. Calvert St.

15 Filed_____ 19____ C. HAMPSON JONES, M. D.

Per_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

Obstruction of the Coronary Arteries.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M.D. (Coroner)

6/2, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. Date of Burial June 3 1927

20 UNDERTAKER William Cook ADDRESS 602 E. North Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22786

CERTIFICATE OF DEATH.

E 22786

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 N. Fremont St., 20 Ward)

2-FULL NAME Frances R. Collins

(a) RESIDENCE NO. 1108 N. Fremont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Oliver Collins

6 DATE OF BIRTH (month, day, and year): Jan. 3, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Pleton

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Norris

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Betty Eisenhart

(Address) 2714 Belair Rd.

15 Filed ....., 19—. J. M. S. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

June 4, 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: June 6 1927

20 UNDERTAKER: W. H. Cook ADDRESS: 501 E. Northern

Cor.—12-9-25—A Co.—200 Bks.

E 22787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ E 22787

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 4-25 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Harrison Traylor

(a) RESIDENCE NO. 115 North Paca St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Traylor ZBH.

6 DATE OF BIRTH (month, day, and year) February 4, [illegible] 1903

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
~~23~~ 24	3	27 28	

6/8/27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

(c) Name of employer Sparrows Point

9 BIRTHPLACE (city or town) Dinwiddie

(State or country) Virginia

PARENTS

10 NAME OF FATHER William A. Traylor

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Ann Wells

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Virginia

14 Informant Mrs. Elizabeth Traylor

(Address) 115 North Paca Street

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

Per ACH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

Supported (duration) yrs. mos. 4 ds.

CONTRIBUTORY Acute Dilatation Heart

(Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

6/1 . 1927 (Address) Curtis Bay, Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stony Creek, Virginia

Date of Burial June 3 1927

20 UNDERTAKER H. O. Bloom

ADDRESS 1003 W. Balto

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22788

CERTIFICATE OF DEATH

E 22788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospl St. 11-24 Ward)

2-FULL NAME Pedro Cruz - (Cruz)

(a) RESIDENCE NO. 1009 Jenkins Alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 27. Years Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Porto Rico

(State or country)

PARENTS

10 NAME OF FATHER St Pedro Cruz -

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Valentina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Porto Rico

14 Informant Balto City Hospt

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to May 27, 1927

that I last saw him alive on May 27, 1927

and that death occurred, on the date stated above, at 5:15 a m.

The CAUSE OF DEATH* was as follows:

Ulcerated Stricture Resulting in Fistula Empyema Extravasation of Urine & Abdominal Wall Pneumonia (duration) Weeks mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of May 23, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) C. Blizzard M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart

Date of Burial: 6/2 1927

20 UNDERTAKER: J J Fahey Son

ADDRESS: 1318 Light St

Very Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22789 90 E 22789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 23-31 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gribauskas (Gribauskas)

(a) RESIDENCE NO. 1031 S. Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER Nick Gribauskas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anne —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant BALTIMORE CITY HOSPITALS

Address [redacted]

15 Filed 19 Registrar

1927 G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1927, to May 30, 1927, that I last saw him alive on May 29, 1927, and that death occurred, on the date stated above, at 4:39 m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [redacted], M. D.

May 31 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 6/2 1927

20 UNDERTAKER J. J. Fahey Sons — ADDRESS 130 S. Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22790

CERTIFICATE OF DEATH.

101-001

E 22790

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 N. Front St. St. 5-8 Ward)

2-FULL NAME Andrew Streets.

(a) RESIDENCE NO. 109 N. Front St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	About 60	---		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Do not know.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Do not know.

14 Informant (Address): Police Report. C.D.

Filed JUN 3 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

Body found May 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body very much decomposed, unable to detetmine exact cause probably Pneumonia.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) 1 yrs. ___ mos. ___ ds.

(Signed) H. W. Reinhardt M. D. (Coroner)

6/2 · 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., ...mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Date of Burial: June 3 1927

20 UNDERTAKER: John A. Denny ADDRESS: 715 Light St

JUN 3 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22791

CERTIFICATE OF DEATH.

129

E 22791

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N. Mount ST. 16-27 WARD)

2-FULL NAME James R. Stanton

(a) RESIDENCE No. 622 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 07

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
	18	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Carrie Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Stanton
(Address) 622 N. Mount St.

15 Filed JUN 3 - 1927 H. H. Hampton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18 - 1927, to June 1, 1927, that I last saw h[illegible]ive on May 31, 1927, and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) M. G. Kennard, M. D.

6-1, 1927 (Address) 708 Enson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prob Va

DATE OF BURIAL June 3 1927

20 UNDERTAKER Simon Chas Hood

ADDRESS Mosby

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22792

CERTIFICATE OF DEATH.

REGISTERED No. E 22792

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1509 Rippas Ave ST. 16-22 WARD)

2-FULL NAME Sadonia Mackel

(a) RESIDENCE No. 1509 Rippas Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11-22

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
4	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Mackall

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Haynie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Beatrice Mackall (Address) 1509 Riggs Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1927

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to June 2 - 1927, that I last saw her alive on June 1 - 1927, and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr G Wilmer M. D.

6-2, 1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Auburne — DATE OF BURIAL June 4 1927

20 UNDERTAKER Sam'l N. Brase & Son — ADDRESS Was Madison

G. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22793

CERTIFICATE OF DEATH

31

E 22793

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Balto city Hosp St.) (Ward 23-31)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George dwight

(a) RESIDENCE NO. 61 W Wist st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 11 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Annie Dwight

6 DATE OF BIRTH (month, day, and year): Feb 22-69

7 AGE — Years: 58 Months: 3 Days: 10

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or estsblishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country)

PARENTS

10 NAME OF FATHER: Chas Wright

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Cartmil

13 BIRTHPLACE OF MOTHER (city or town): md

(State or country)

14 Informant: Dausly Wesley

(Address) 1316 Pennsylvania Ave

N 3 1927 HAMPSON JONES M. D.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-2-27

17 I HEREBY CERTIFY, That I attended deceased from 3-17-27 19 to 6-2-27 19

that I last saw h[illegible] alive on 6-2-27 19

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation preeede death? yes Date of 5-21-27

Was there an autopsy? no

What test confirmed diagnosis? Phy findings

(Signed) Wm Robertson M. D.

6-2 19 27 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial June 4 19 27

20 UNDERTAKER: Sam H. Chase & Son — ADDRESS 1900 Madison

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22794

CERTIFICATE OF DEATH.

66

REGISTERED E 22794

1-PLACE OF DEATH

City of BALTIMORE: (No. 753 N. Lexington St., 4-26 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustavus Maddox

(a) RESIDENCE NO. 753 N. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	N	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma G. Maddox

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lovely Drummer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Md

10 NAME OF FATHER Gustavus Maddox

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Ballard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

PARENTS

14 Informant F. C. Maddox

(Address) Millington Md

Filed JUN 3 - 1927 C. HAYDON JONES, M. D. Registrar

Per R.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. C. Yates M. D.

(Coroner)

June 1, 19 27 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 753 N. Lexington

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Date of Burial June 3 1927

20 UNDERTAKER Wilson Cook ADDRESS 307 E North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22795

CERTIFICATE OF DEATH.

90 E 22795

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1901 Edgewood (St.) 15-61 (WARD)

2-FULL NAME Susie F Reiter

(a) RESIDENCE NO. 1901 Edgewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert H Reiter

6 DATE OF BIRTH (month, day, and year): March 24-1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	2.	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Levi Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Martha Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

PARENTS

14 Informant: Albert H Reiter

(Address): 1901 Edgewood

Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926, to June 1, 1927.

that I last saw h[illegible] alive on June 1, 1927.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

myocarditis - arteriosclerosis - angina pectoris

about 6 years (duration)

CONTRIBUTORY (Secondary) acute dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter Niblett M. D.

June 3/27 (Address) 2220 Garrison av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert Cemetery — DATE OF BURIAL: June 3 19 27

20 UNDERTAKER: [illegible] — ADDRESS: North Ave

Spec.—1-12-23—M&T—500 Blks.

E 22796

HEALTH DEPARTMENT—CITY OF BALTIMORE E 22796

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 W. Belvidere Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hamilton Collett

(a) RESIDENCE NO. 113 W. Belvidere Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jane Collett

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer U.R.&E. Co. Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Ephraim Collett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Irwin Collett.

(Address) 5318 Maple Ave.

15 Filed 3-1927. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 19 27, to June 2, 19 27, that I last saw h alive on June 2, 19 27, and that death occurred, on the date stated above, at 9.15a

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Unknown

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

6/6, 19 27 (Address) 517 Fonda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem. Hampden — DATE OF BURIAL June 6, 1927

20 UNDERTAKER Wm. Tucker Sons — ADDRESS North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22797

CERTIFICATE OF DEATH.

90 Edward

E 22797

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 27-43 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Flora Bailey

(a) RESIDENCE NO. 624 Carton Rd. ST. Hamilton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Bailey

6 DATE OF BIRTH (month, day, and year) Oct 30 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Gick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Husband. (Charley J. Bailey) (Address) 624 Carton Rd Catonsville

15 Filed 3 - 1927 19 Per R.H. Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to June 2, 1927.

that I last saw h[illegible] alive on June 2, 1927

and that death occurred, on the date stated above, at 9½ a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio vascular disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cemetery — DATE OF BURIAL June 4, 1927

20 UNDERTAKER Elmer W. Conklin — ADDRESS 924 E Eager St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22798

CERTIFICATE OF DEATH.

REGISTERED E 22798

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE; (No. Church Home & Infirmary St. Ward)

2-FULL NAME Frederick Schulke

(a) RESIDENCE NO. Preston, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30th 1905

7 AGE: Years 21 | Months 5 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Preston

(State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Schulke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Amalia Fleckenstein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Amalia Schulke

(Address) Preston Md.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 1927, to June 3, 1927, that I last saw him alive on June 3, 1927, and that death occurred, on the date stated above, at 12-30 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis (Mitral and Cardiac Insufficiency)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

June 3 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Preston Md. Date of Burial June 3 1927

20 UNDERTAKER: Frederick Loeschner Sons ADDRESS Fullerton

JUN 1927 HAMPSON

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22799

CERTIFICATE OF DEATH

E 22799

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 N Milton Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Eisenhut

(a) RESIDENCE NO. 721 N Milton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: ~~Male~~ ~~Female~~

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dorothea A Chase

6 DATE OF BIRTH (month, day, and year): Sept 18th 1867

7 AGE: Years 59 Months 9 Days 8

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Policeman

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Chas Eisenhut

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Lowe Kerr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Dorothea Eisenhut

(Address): 721 N Milton Ave

15 Filed 19 C. HARRISON JONES, M. D. Registrar

JUN 3 - 1927 Per K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 1 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1927, to June 1st, 1927, that I last saw h alive on 19, and that death occurred, on the date stated above, at 4 1/2 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Tankin, M. D.

, 19 (Address) 1192 N. Milton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: June 4 1927

20 UNDERTAKER: John Weiss

ADDRESS: 2008 Oliver

Sec. Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

È 22800

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

È 22800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City Hospital

City of BALTIMORE: (No. 94 S. Potomac St., 1-1 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Stokes

(a) RESIDENCE NO. 1103 S. Streeper St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 10

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Wilson Stokes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Tobithia Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Oklahoma

14 Informant Wilson Stokes Trotter

(Address) 1100 S. Streeper St

15 Filed MAY 13 1927 HAMPSON JONES, M. D. Registrar

Rgt R.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) C Lawson

(duration) yrs. mos. ds.

(Signed) G C Wades M. D.

(Coroner)

May 21, 1927 (Address) 143 W 13 way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery Date of Burial June 4 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe

Spec.—1-12-23—M&T—500 Bks.

E 22801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 22801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 George ST., 17-24 WARD)

2-FULL NAME Mary E. Williams

(a) RESIDENCE NO. 644 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel F Williams

6 DATE OF BIRTH (month, day, and year): May 16 1865

7 AGE: Years 62 Months Days 15 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas R. Bishop.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Sarah Madera

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Upton Williams 644 George st

15 Filed 3 1927 Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1927, to June 1, 1927

that I last saw her alive on June 1, 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W= J. Carr, Jr., M. D.

June 3 1927 (Address) 515 Mrather

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: 6/4/27

20 UNDERTAKER: Mrs. R.U. Elliott — ADDRESS: 525 Washington

JUN 3 - 1927

Spec. 27-1 ... Bks.

E 22802

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22802

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

REGISTERED NO. 23-31

City of BALTIMORE: (No. 104 W. Beverly St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Spoerlein

(a) RESIDENCE NO. 104 W. Beverly St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry J. Spoerlein

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1848

7 AGE: Years 79 Months 3 Days 10 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Miller

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Sondhoff

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: John J. H. Spoerlein

(Address): 104 W. Beverly St

15 Filed JUN 3 - 1927 19 C. HAMPSON JONES, M. Registrar

Per Edward C. Howard

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 1, 1927 - 11:50 P.M.

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to June 1, 1927, that I last saw her alive on June 1, 1927, and that death occurred, on the date stated above, at 11-50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

June 2, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: June 7, 1927

20 UNDERTAKER: Edward C. Howard Exam. ADDRESS: 28 E. Fort Ave.

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22803 — 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Cliftview ave ST., 8-45 WARD)

2-FULL NAME Margaret E Brady

(a) RESIDENCE No. 1235 Cliftview ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

129 — E 22803 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): apr 14 1868

7 AGE — Years: 59 — Months: 2 — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Daniel Loughrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Ann Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret E Brady

(Address): 1235 Cliftview Ave

15 Filed JUN 3 - 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov — 1926 to June 2" 1927.

that I last saw h[illegible]ive on June 1 — 1927

and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows: Complications of Diseases

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Chron Myocarditis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) H Huntington M. D.

19 (Address) 1306 Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 6/4 1927

20 UNDERTAKER: J. J. Moran

ADDRESS 3006 E Baltimore

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22804

10-002

CERTIFICATE OF DEATH

E 22804

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 N Ellwood St., 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. P. Evans Jr.

(a) RESIDENCE NO. 314 N Ellwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 9 - 1924

7 AGE: Years 2 Months 10 Days 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): City

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edw. P. Evans Jr.

11 BIRTHPLACE OF FATHER (City or town): —

(State or country): —

12 MAIDEN NAME OF MOTHER: Sallie Richardson

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country): Va.

14 Informant: Edw. P. Evans Jr.

(Address): 314 N Ellwood Ave

15 Filed ..... 19 .....

Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 27 19 27 to June 2 19 27

that I last saw him alive on June 2 19 27

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (M. T. C.)

(duration) — yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted: —

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) W. H. Grades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

Date of Burial: 6 Jun 1927

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 22805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 22805

1-PLACE OF DEATH Maryland Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... St., 12-19 Ward)

2-FULL NAME Joseph A. Rinn

(a) RESIDENCE NO. 1701 N. Charles St. St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Organist

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John S. Rinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Rinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D C

14 Informant Mrs. C. Naughton
(Address) 1701 N. Charles

15 Filed 1927 19 C. HAMPSON JONES M.D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927 to June 1, 1927, that I last saw h[illegible] alive on June 1, 1927 and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? ....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Union Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 6/4 1927

20 UNDERTAKER Geo. A. Farley Sulton & Fayette

ADDRESS

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22806

CERTIFICATE OF DEATH

E 22806

1-PLACE OF DEATH Woman's Hospital. REGISTERED NO. 46

City of BALTIMORE: (No. John St. & Lafayette Ave. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Eugenia Stuart.

(a) RESIDENCE NO. 1418 W. Royal Ave St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 6 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 59 yrs. 4 mos 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced (or) WIFE of Wm. S. E. D. Stuart.

6 DATE OF BIRTH (month, day, and year) Jan. 27, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER J. L. A. Robson

11 BIRTHPLACE OF FATHER (City or town) Talbot Co, (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anne E. Clarke

13 BIRTHPLACE OF MOTHER (city or town) St Mary's Co, (State or country) Maryland.

14 Informant Wm. S. E. D. Stuart Husband (Address) 1418 W. Royal Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar Per R.R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to June 2, 1927, that I last saw her alive on June 2, 1927, and that death occurred, on the date stated above, at 7:12 A M.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of cervix.

(duration) 4 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Toxemia. Myocardial failure (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 5, 1922

Was there an autopsy? No!

What test confirmed diagnosis? C. & C. - pathology

(Signed) Wm M Wilson, M. D.

, 19 (Address) Women's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial June 7 1927.

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. HOWEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Blks.

E 22807 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22807

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 E. Oliver St. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick E. Schaaf

(a) RESIDENCE NO. 2223 E. Oliver ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Schaaf

6 DATE OF BIRTH (month, day, and year): July 16th 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer: Schloss Bros.

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Peter Schaaf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Hummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Germany

14 Informant: Minnie Schaaf

(Address) 2223 E. Oliver St.

15 Filed ..... 19 ..... Registrar .....

C. HAMPSON JONES, M. D.

1927 Per R.C.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1927

17 I HEREBY CERTIFY, That I attended deceased from ✓ 1, 1927, to 6/2, 1927, that I last saw him alive on 6-2, 1927, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 2. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 3. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs - Urine

(Signed) David Miller, M. D.

6-7-27 (Address) 1500 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Immanuel Cemetery — DATE OF BURIAL: June 5 27

20 UNDERTAKER: Frederick Leach Sons Home — ADDRESS: Fulberton

Spec.—12-9-25—A Co.—200 Bks.

E 22808

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. St. Ward)

2-FULL NAME Charles Winters

(a) RESIDENCE NO. 502 N. Castle St — St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13-55-

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery man

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER Jacob Winters

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Hahn

13 BIRTHPLACE OF MOTHER (city or town): Ger —

(State or country)

14 Informant: Records — JOHNS HOPKINS HOSPITAL

(Address)

15 1927 C. HAMPSON JONES, M. D.

Per RRA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1927

17

I HEREBY CERTIFY, That I attended deceased from May 16 1927, to June 2, 1927, that I last saw him alive on June 2, 1927, and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Everett Sayner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — Date of Burial: 6/4 1927

20 UNDERTAKER: L. F. McCully — ADDRESS: 130 E. Fort

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22809

CERTIFICATE OF DEATH. 185X

E 22809

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 47 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Geilfuss.

(a) RESIDENCE NO. Franklin Rd. Woodlawn. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (XXXXXXXX) Marie O. Geilfuss.

6 DATE OF BIRTH (month, day, and year) November 8, 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter helper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina,

PARENTS

10 NAME OF FATHER Charles R. Geilfuss.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Quinn.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Marie O. Geilford. (wife)

(Address) Franklin Rd. Woodlawn.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Accidental fall from a platform.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Stahl Steinhardt M. D.

(Coroner)

6/3, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

New Municipal Building, June 1, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial June 4 1927

20 UNDERTAKER Mary E. Gawithop ADDRESS 7800 Ragnor

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-22810

CERTIFICATE OF DEATH

E 22810

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 527 Dulaney St 22-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Jones

(a) RESIDENCE NO. 527 Dulaney St

(Usual place of abode) St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S. if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) N.G.

(c) Name of employer

9 BIRTHPLACE (city or town) /

(State or country) N C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) Unknown

(State or country)

14 Informant Emma McBride

(Address) 527 Dulaney St

15 Filed 1927 C. HAMPSON JONES, M. D. 16 Registrar

Per RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 3 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to June 3, 1927, that I last saw her alive on June 3, 1927, and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H. Hooker, M. D.

Jun 3 1927 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem Jun 3 1927

20 UNDERTAKER Harold Eastman ADDRESS 916 Gay St

Very Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22811 51 E 22811

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Providence Hosp. 18-16 Ward.

2-FULL NAME Levicia Burgess

(a) RESIDENCE NO. 914 W. Fayette St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 26, 1912

7 AGE: Years 15 Months 4 Days 7

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): June 3

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Burgess

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: John Burgess

(Address): 914 W. Fayette St.

15 Filed _____ 19 ____ THOMPSON JONES, M. D. Registrar

June 3 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ____ yrs. 6 mos. ____ ds.

CONTRIBUTORY (Secondary) Uncertain.

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Thompson M. D.

(Coroner)

1927 (Address) 502 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: June 3 1927

20 UNDERTAKER: Hurst Eaton ADDRESS 916 Pine

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22812 74-021 E 22812

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1131 N. Carey St.) (16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Clark

(a) RESIDENCE NO. 1131 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1887

7 AGE: Years 39 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General
(c) Name of employer

9 BIRTHPLACE (city or town): June 23, 1927
(State or country): N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Norman Clark
(Address) 604 Dolphin St

15 Filed ..... 19 ..... Registrar

1927 APH

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

(Address) 1802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn June 3 1927

20 UNDERTAKER Daniel Carton ADDRESS 846 Cove

Spec.-7-17-26—A Co.—200 Bks.

Mc Garry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22813

CERTIFICATE OF DEATH

31 E 22813

1-PLACE OF DEATH

REGISTERED NO. 9231

City of BALTIMORE: (No. Baltimore City Hospitals (C.H.) St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie McGarry

(a) RESIDENCE NO. Baltimore City Hospitals St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE About 40 Years Months Days IF LESS than 1 day hrs. or min.
Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1910, to June 1 1927,

that I last saw her alive on June 1 1927,

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

C.V.-R. Disease with Hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. McCullers, M. D.

6-1-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 6/4 1927

20 UNDERTAKER — ADDRESS

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22814

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. marine Hospital #1

CITY OF BALTIMORE: (No. Baltimore, Md ST., 17-51 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dan Flood.

(a) RESIDENCE NO. 18 Rich St San Francisco Calif WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 18, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39 48	8	13 1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): Oiler.

(c) Name of employer: S/S Hanley.

9 BIRTHPLACE (city or town) (State or country): California

PARENTS

10 NAME OF FATHER: Dan Flood

11 BIRTHPLACE OF FATHER (city or town) (State or country): California

12 MAIDEN NAME OF MOTHER: Margaret Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: self

(Address)

15 Filed June 6, 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1927

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1927 to June 1, 1927.

that I last saw him alive on June 1, 1927

and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease, mitral incompetency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Pyelonephritis, acute

(duration) — yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings + laboratory tests

(Signed) W W Denton M. D.

Asst. Surgeon U.S.P.H.S.

6/2 1927 (Address) U. S. marine Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: E. Leroy Stiffler — DATE OF BURIAL: June 4, 1927

20 UNDERTAKER: St Mary's Hampden — ADDRESS: 125 E North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22815

CERTIFICATE OF DEATH.

118 E 22815

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Greene + Lombard St. 14-20 Ward)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Gladhill

(a) RESIDENCE NO. St. Vincents Infant Asylum St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. ½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-20-27.

7 AGE — Years: 0 — Months: 0 — Days: 13 — If LESS than 1 day, hrs. or min.: 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alfred Gladhill Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Mary E. Gladhill.
(Address) 140 Durham St

15 Filed JUN - 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-2-27, to 6-3-27, 19

that I last saw him alive on 6-3-27, 19

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia.

Hernia since birth (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Strangulated (duration) 2 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 6-2-27

Was there an autopsy? no

What test confirmed diagnosis? Fat. + clinical

(Signed) E. T. Keagan den, M. D.

, 19 (Address) University Hospital Greene + Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 6-4-27

20 UNDERTAKER: Marston Eakes Sons — ADDRESS: Baltimore

Spec.—1-12-23—M&T—500 Bks.

(Nettie D Beasley) Letter in file from Dr Mary E R S Anderson dated June 7/14/27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22816

CERTIFICATE OF DEATH.

+ 118

E 22816

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ. Hosp. (St.) W. Lombard (Ward) 11-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Beasley Nettie D.

(a) RESIDENCE NO. Odenton - (St.) Anne Arundel County (Ward) - Md.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W L

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: George Thomas Beasley

6 DATE OF BIRTH (month, day, and year): Oct 15 1868

7 AGE: Years 58 | Months 7 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anna Arundel Co.

PARENTS

10 NAME OF FATHER: John E. Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co.

12 MAIDEN NAME OF MOTHER: Mary Poulton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mary R. Myers (Address) Odenton, Md

15 Filed ... 19 27 C. HAMPSON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1927

I HEREBY CERTIFY, That I attended deceased from May 31 1927 to June 2 1927

that I last saw h alive on June 2 1927

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows: Myocardial Failure

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-31-27 6-2-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. S. Anderson, M. D.

(Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy. DATE OF BURIAL: June 4, 1927

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS: 1900 Eutaw Pl

Spec.—12-9-25—A Co.—200 Bks.

E 22817

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 22817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Raburg

(a) RESIDENCE NO. 2712 Eastern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life 54 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1872

7 AGE: Years 54 Months 10 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Raburg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susan Beckenridge

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

14 Informant [redacted] BALTIMORE CITY HOSPITALS

(Address) [redacted] Reads

15 Filed 19 Per Registrar

1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1927

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to May 31, 1927, that I last saw h.im alive on May 31, 1927, and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Insufficiency

Chronic Nephritis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & Laboratory

(Signed) A Stoppe Lunt, M. D.

May 31 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in Violent Cases, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial June 1 1927

20 UNDERTAKER: F. D. Wiskott ADDRESS: 1850 N. Balto St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22818 | CERTIFICATE OF DEATH | E 22818

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2124 E. Chas St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Meikel

(a) RESIDENCE NO. 2124 E. Chas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Marie Meikel

6 DATE OF BIRTH (month, day, and year): May 13th 1863

7 AGE: Years 64 Months 6 Days 21 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 06

(c) Name of employer: Merten Md Pr. R

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Schimmick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Lena M. Meikel

(Address): 2124 E. Charles St

15 Filed: 1927 16 C. HAMPSON JONES, M. D. Registrar

Per RDH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to June 3, 1927, that I last saw h[e] alive on June 2 1927, and that death occurred, on the date stated above, at 5.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. Mhelde M. D.

(Address) 1279 Milliam N

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Date of Burial 6/6/27

20 UNDERTAKER: Geo. Weber & Son ADDRESS 2503 Edmon Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22819

E 22819

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1405 Ettinge Av. St. 14th Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D Stewart

(a) RESIDENCE NO. 1405 Ettinge Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 64 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): for

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Stewart

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Charity Bell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Minnie Stewart

(Address) 1 Hartz Place Catawba City Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. 6 mos. ds.

(Signed) D. T. Hennessy M. D. (Coroner)

(Address) June 2, 1927 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial: 6/4/1927

20 UNDERTAKER: Samuel P Hemsley

ADDRESS 578 W Baltimore

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22820 E 22820

CERTIFICATE OF DEATH

74-004

1-PLACE OF DEATH Aged Womens Home REGISTERED NO. 14-27

City of BALTIMORE: (No. S. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E House

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 9 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 25/1837

7 AGE: Years 89 Months 5 Days 8 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Unknown

14 Informant Ella F. Jones

(Address) 1400 W Lexington

15 Filed JUN 1927 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927. to June 3, 1927.

that I last saw h alive on June 3, 1927.

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, 11.

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage, 11.

(duration) 5 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward [illegible] M. D.

. 19 (Address) 1126 E. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial June 6 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22821

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 North Patterson Park Ave ST. WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Boland

(a) RESIDENCE No. 933 N. Patterson Park Ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ....

6 DATE OF BIRTH (month, day, and year) August 15. 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	17	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Rudolph F. Boland

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Svitak

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14 Informant Rudolph F. Boland
(Address) 933 North Patterson Park.

15 Filed ... 1927 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 18", 1927, to June 3", 1927, that I last saw h[er] alive on June 3", 1927 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Septic Encephalitis.

(duration) yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary) Mastoiditis

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Yes Date of Apr 18"-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hedges Lonedale, M. D.

June 4" 1927 (Address) 124 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 6 1927

20 UNDERTAKER August Park

ADDRESS 2406 Ashland ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22822

22822

CERTIFICATE OF DEATH

REGISTERED NO. 31 E 22822

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (Dept. or Ward) St. 7-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Boots

(a) RESIDENCE NO. 203 W. Montgomery st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Boots

6 DATE OF BIRTH (month, day, and year) 1889 ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	38 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER K. Holmon

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Matilda Sesson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to June 2, 1927, that I last saw her alive on June 2, 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Gaither M. D.

6-2-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct Date of Burial June 3 1927

20 UNDERTAKER S. R. Brown & Son ADDRESS Baltimore Md

Keep this certificate clean and free from folds. Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22823

CERTIFICATE OF DEATH

90 E 22823

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital 9-16 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret B. Winn

(a) RESIDENCE NO. 1330 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas P. Winn

6 DATE OF BIRTH (month, day, and year): Unk.

7 AGE: Years 50 Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer): maid.

(c) Name of employer: Telephone Co. 07

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md

14 Informant: Mrs E. Shanahan

(Address): 101 S. Carrollton Ave

15 Filed JUN 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3-1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to June 3, 1927, that I last saw her alive on June 3, 1927, and that death occurred, on the date stated above, at 11:45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

Sec. Anemia -

Acute Dilatation -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted: at home

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank R. Dieudonné, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: June 6 1927

20 UNDERTAKER: Chas. S. Maus & Son — ADDRESS: 1158 Montpelier

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2628 14 E 22824

CERTIFICATE OF DEATH.

+ 44 ✓

E 22824

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ernest

(a) RESIDENCE NO. Reedsville - Northumberland Co Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. mos. 24 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-19-1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER Joseph Ernest

11 BIRTHPLACE OF FATHER (city or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Theresa Hart-

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed ____ 19 ____ C. HAMPTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7 1927, to June 3, 1927, that I last saw h~~is~~ alive on June 3, 1927, and that death occurred, on the date stated above, at 7 18p- m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Reedsville Pa

Did an operation precede death? Yes Date of 5-11-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Morris Myers, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reedville Pa Date of Burial 6/5/27

20 UNDERTAKER Joseph Adrens ADDRESS 221 Bailey

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22825

CERTIFICATE OF DEATH.

21 E 22825

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Phillip Kornmann

(a) RESIDENCE No. 716 N Caroline St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 29, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	46	8	6	5-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Salesman 066

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Kornmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louisa Spillmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Singwald (Sister)

(Address) 1520 N Broadway

15 Filed JUN 5 1927 19 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to June 4, 1927, that I last saw h[illegible] alive on June 4, 1927, and that death occurred, on the date stated above, at 8 40 a m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 33 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron B. Tull, M. D.

6/4, 1927 Address Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL June 6th 1927

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

FROM A very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22826

CERTIFICATE OF DEATH.

129 E 22826

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Askin

(a) RESIDENCE NO. 1833 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Bell Askin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Dairy Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Sara Askin

(Address): 1833 Linden Ave

15 Filed ..... (19 .....) ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: June 30

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to June 3, 1927, that I last saw h. alive on June 3, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical - Lab.

(Signed) Wm Schuman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Cem

Date of Burial: 6/5 1927

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 Eutaw St

G. HAMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22827

CERTIFICATE OF DEATH.

31 E 22827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Cresbury St. ST. 15-21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Weitzman

(a) RESIDENCE NO. 1807 Cresbury St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Weitzman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Louis 1439 E Balto St

15 Filed NOV - 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to June 4, 1927, that I last saw h... alive on June 4, 1927, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Noah Gillis, M. D.

, 19 (Address) 1304 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 6/5 1927

20 UNDERTAKER Jack Louis 1434 E Balto St — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

E 22828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1855

E 22828

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. St. Agnes Hosp. St. 25-72 Ward)

2-FULL NAME Mrs Louisa B. Eldridge

(a) RESIDENCE NO. Halethorpe Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? __ yrs. __ mos. __ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or WIFE of) Gardner Eldridge

6 DATE OF BIRTH (month, day, and year) Dec 15th 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	82	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila. Pa

(State or country)

PARENTS

10 NAME OF FATHER Joseph Stacey

11 BIRTHPLACE OF FATHER (city or town) Philadelphia Pa

(State or country)

12 MAIDEN NAME OF MOTHER Melissa Stapleford

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia Pa

(State or country)

14 Informant Mrs La Crosse

(Address) Halethorpe Md

15 Filed 1927 G. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4-1927

17 I HEREBY CERTIFY, That I attended deceased from 5-21 1927, to 6-4 1927,

that I last saw h__ alive on 6-4 1927,

and that death occurred, on the date stated above, at 7 50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) __ yrs. __ mos. __ ds.

CONTRIBUTORY (Secondary) Fracture of hip

(duration) __ yrs. __ mos. __ ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. L. Padgett M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

Date of Burial June 6th 1927

20 UNDERTAKER

ADDRESS F. B. Wippert 1650 N. Dallo St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22829

CERTIFICATE OF DEATH.

74 001

E 22829

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 E. Lakewood Ave ST., 7-12 WARD)

2-FULL NAME Henry Weidel

(a) RESIDENCE NO 825 E. Lakewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Weidel

6 DATE OF BIRTH (month, day and year) Sept 10th 1846

7 AGE — Years: 80 — Months: 8 — Days: 23 — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Florist

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Weidel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rubenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Dr. Meyer
(Address) 825 E. Lakewood Ave

15 Filed JUN 5 - 1927 19... C. HAMPSON JONES, M. D. Registrar
Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927 to June 2 1927.
that I last saw him alive on June 2 1927
and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White M.D.

6/3 1927 Address) 2800 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 6th 1927

20 UNDERTAKER: J. B. Hilgent — ADDRESS: 1850 N. Dallas St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22830

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

170

E 22830

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernst V. DUNLEVIE

(a) RESIDENCE NO. York Wyman Apartments St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	wuite	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kathryn Tyre Dunlevie

6 DATE OF BIRTH (month, day, and year) Dec 8/1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	5	27 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada

PARENTS

10 NAME OF FATHER Horace Dunlevie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Rngland

12 MAIDEN NAME OF MOTHER Alice E. Cooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant George B. Cooper

(Address) Belvedere Hotel

15 Filed JUN 5 - 1927 K.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bistol shot wound inbrain-Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

6/4/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Lawn Buffalo N.Y. Date of Burial June 7/27

20 UNDERTAKER George J. Smith ADDRESS Fulton St

Spec.–7-17-26—A Co.—200 Bks.

E 22831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 22831

1-PLACE OF DEATH

REGISTERED NO. 1927

City of BALTIMORE: (No. Maryland general St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Mercer

(a) RESIDENCE NO. 8 Tricks + Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7 6 14, 1846.

7 AGE: Years 81 Months 3 Days 15 14

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Robert Mercer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Jane Graham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Hospital Records

(Address)

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-3- 1927 to 6-4- 1927

that I last saw h.. alive on 6-4 1927

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cor Myocarditis with Hypertension

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 1 day Pulmonary edema 12 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: June 7 1927

20 UNDERTAKER: George J. Smith ADDRESS: Hotema Md

Key important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 22832

E 22832 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3911 Bonner Road St. 1565 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Rolph Starkey

(a) RESIDENCE NO. 3911 Bonner Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac R. Starkey

6 DATE OF BIRTH (month, day, and year): Dec 23. 1858

7 AGE: Years 68 Months 5 Days 11 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: John Rolph

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Rachel Tarbutton

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Blanche H. Starker

(Address) 3911 Bonner Road

15 Filed ... 19 ... Registrar

C. HAMPTON JONES, M. D.

N5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from April-3. 1927. to June 3. 1927.

that I last saw her alive on June 1927.

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder (duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marion A. Shook M. D.

(Address) 806 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sudlersville Md. Date of Burial June 6 1927

20 UNDERTAKER: John O. Mitchell & Sons ADDRESS 800 Eutaw Place

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22833

E 22833

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1721 Laurens ST. 16-2nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Sullivan

(a) RESIDENCE NO. 1721 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgine Sullivan

6 DATE OF BIRTH (month, day, and year): June 27, 1852

7 AGE — Years: 74 — Months: 11 — Days: 5 — If LESS than 1 day, hrs. or min.: 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 7 yrs.

(c) Name of employer: Post Office

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Peola Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester Md.

12 MAIDEN NAME OF MOTHER: Rachael Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Georgine Sullivan

(Address): 1721 Laurens St.

15 Filed ....., 19 1927 C. HAYWOOD JONES, M.D. Registrar

Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1927

17

I HEREBY CERTIFY, That I attended deceased from May 27 - , 1927, to June 2, 1927, that I last saw him alive on June 2, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease and arteriosclerosis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Bronchial pneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. J. Kellen, M. D.

6/4, 1927 (Address) 222 Monument E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: June 6 1927

20 UNDERTAKER: Wm Fickus Sons

ADDRESS: North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22834

CERTIFICATE OF DEATH.

E 22834
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward) 37-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gibson, Edna Mirie

(a) RESIDENCE NO. 502 Oakland Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 1 mos. 20 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or WIFE of): E Samuel Gibson

6 DATE OF BIRTH (month, day, and year): April 14, 1899

7 AGE: Years 28 | Months 1 | Days 19/20 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Quinn Dixon

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Viola MacGregor

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mr. Samuel E. Gibson

(Address) 502 Oakland Ave.

15 Filed ....., 19 G. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to June 3, 1927, that I last saw her alive on June 3, 1927, and that death occurred, on the date stated above, at 3:18 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis +
Septicemia
(Operation performed for drainage of peritoneal cavity + removal of uterus)

(duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 29, 1927

Was there an autopsy? No

What test confirmed diagnosis? Cultures from blood & pus

(Signed) Wm. P. Bretham M. D.

June 3 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial June 6 1927

20 UNDERTAKER: Wm Fleckner & Son ADDRESS Rochester

E 22835

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. E 22835

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 N Lexington St. 18-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saml Beans

(a) RESIDENCE NO. 825 N. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise E Brown Beans

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis

(State or country) Md

PARENTS

10 NAME OF FATHER Daniel Beans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Peters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Louise Brown Beans

(Address) 825 W Lexington St

15 Filed ..... 19 .....

NOV 5 - 1927 C. HAMPTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

June 5 1927 (Signed) C. Hampton Jones M. D.

(Coroner)

, 19 (Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cmtry Date of Burial 6 5, 1927

20 UNDERTAKER Leon Hall ADDRESS 753 Dolphin st

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22836

CERTIFICATE OF DEATH

118-001

E 22836

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 608 Eisler St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walker

(a) RESIDENCE NO. 608 Eisler St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): ~~Single~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah B Walker

6 DATE OF BIRTH (month, day, and year) Mar. 20, 1883

7 AGE: Years 44 Months 2 Days 14 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cork shaper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Burlington

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Jordan W. Walker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Rachel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

14 Informant Sarah Brashears

(Address) 608 Eisler St

15 Filed 19 G. HAMPSON JONES, M. D. Registrar

Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/25, 1927, to 6/3, 1927, that I last saw him alive on 6/2, 1927, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Very large Hernia Cystitis Urinary Retention

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? Exam @ John Hopkins Hospital

What test confirmed diagnosis? Hospital

(Signed) Dan Drucker, M. D.

6/3, 1927 (Address) 122 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — Date of Burial 6/6, 1927

20 UNDERTAKER: J Leon Hall — ADDRESS 753 Dolphin St

Very important. See instructions on back of certificates.

Spec.—12-9-25—A.C.—200 Bks.

Dr Fontes

2025 14

E 22837

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22837

CERTIFICATE OF DEATH

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1833 N Wolfe St. 8-17 Ward)

2-FULL NAME James Stephens

(a) RESIDENCE NO. 1833 N. Wolfe St. City Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1927

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	3 1/2 Mos	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Stephens

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Alice Trotter

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Records

15 Filed NOV 5 1927 By E. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 24 1927, to June 3 1927, that I last saw him alive on June 3 1927, and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Otitis media one week

Broncho-pneumonia — one day

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Parkwood Cemtry. Jun 6 1927

20 UNDERTAKER ADDRESS

Geo. J. Ruth 1235 Harford ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22838

CERTIFICATE OF DEATH

129

E 22838

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1500 E Lafayette Ave St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Scraggs

(a) RESIDENCE NO. 1500 E. Lafayette Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married -

5a If married, widowed, or divorced (or) WIFE of Ida Scraggs -

6 DATE OF BIRTH (month, day, and year) Dec 1- 1892

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
34	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motor-man - 078

(b) General nature of industry, business, or establishment in which employed (or employer) U. R. & E. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Jas. L. Scraggs, Sr

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Barbour

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Virginia Scraggs -

(Address) 1500 E. Lafayette Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

JUL - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1- 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26 1925 to June 1- 1927

that I last saw h[im] alive on June 1- 1927.

and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

chronic Nephritis -

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Georgia A. Saunders, M. D.

6/1, 1927 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial June 6 1927

20 UNDERTAKER Geo. J. Ruth — ADDRESS 1735 Harford ave

Spec.—8-24-14—M. & T.—2000 Blks.

E 22839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22839

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 Clift View St.; 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Schafer

(Residence in Baltimore: No. 1246 Clift View av St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word.) Widow

6-DATE OF BIRTH, December 29, 1852 (Month) (Day) (Year)

7-AGE, 74 yrs. 5 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, John Thomas

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Schafer

(Address) 1246 Clift View av

15- JUN 5 - 1927 HAMPSON JONES, M. D.
Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1927, to June 2 1927, that I saw h[illegible] alive on June 2 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Valvular disease of the heart

(Duration) ..... yrs. 0 mos. ..... ds.

CONTRIBUTORY (Secondary) Age and general debility

(Duration) ..... yrs. 0 mos. ..... ds.

(Signed) Harry Wetherald M. D.

June 7, 1927 (Address) 1 East Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Matthews Country. DATE OF BURIAL, June 6, 1927

20-UNDERTAKER George J. Ruth ADDRESS 1735 Hayford ave

Spec.—1-12-23—M&T—800 Bks.

E 22840 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 E 22840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Weitzel

(a) RESIDENCE NO. 1322 Steever St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 13, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	4	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER DeWitt T. Weitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Kathryn Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant DeWitt T. Weitzel

(Address) 1322 Steever St.

15 Filed JUN 5 1927 19 C. HAWSON JONES, M. D. Registrar

Per K.P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 5, 1927, that I last saw him alive on June 5, 1927 and that death occurred, on the date stated above, at 7 00 a. m.

The CAUSE OF DEATH* was as follows:

Nasal, Pharyngeal & Laryngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Culture

(Signed) Myron S. Tuell, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemtry DATE OF BURIAL Jun 6 1927

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford Av

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 22841

CERTIFICATE OF DEATH.

E 22841

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Preston & Eutaw

CITY OF BALTIMORE: (No.) Preston Apartments ST. 11-19 WARD)

2-FULL NAME Wilson Severing Condon

(a) RESIDENCE NO. Preston apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept Insurance Com

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer State Gov

9 BIRTHPLACE (city or town) (State or country) Perryville Md.

PARENTS

10 NAME OF FATHER Henry J. Condon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Severing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilson L. Condon Jr. (Address) Aikin, Md.

15 Filed JUN 5 - 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to 6-5, 1927, that I last saw h'm alive on 6-5, 1927, and that death occurred, on the date stated above, at 8.00 A m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(ARTERIOSCLEROSIS, HYPERTENSION)

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Donley, M. D.

, 19 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harbison Aikin, Md DATE OF BURIAL June 7 1927

UNDERTAKER Rees A Patterson ADDRESS Perryville Md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22842 — 1-PLACE OF DEATH

90

REGISTERED NO. E 22842

City of BALTIMORE: (No. 2800 Oak St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Gibbs

(a) RESIDENCE NO. 2800 Oak St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Thompson Gibbs

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	69	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Archibald C. Gibbs

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Mrs. Emily T. Gibbs

(Address) 2800 Oak St.

15 Filed JUN 5 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R. K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1927, to June 3 1927, that I last saw him alive on June 3, 1927, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

about (duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) P. L. Eyler M. D.

19 (Address) June 4-27 Wellworth Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — Date of Burial: June 6 1927

20 UNDERTAKER: John C. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 22843 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 E 22843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1542 N. Stricker ST.) 15-21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Henderson

(a) RESIDENCE NO. 1542 N. Stricker ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20 21	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Thrift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lenora Henderson
(Address) 1542 N. Stricker St.

15 Filed JUN 5 1926 19 HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3 1927, to June 3 1927, that I last saw h[illegible] alive on June 3 1927 and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Casey, M. D.

, 19 (Address) 1624 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	June 6, 1927

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 127 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001

E 22844

REGISTERED NO. E 22844

1-PLACE OF DEATH E 22844 Kate Ave. and Western Maryland Railroad Tracks. St. 15-63 Ward)

City of BALTIMORE: (No.

2-FULL NAME Edward Sherman Levy

(a) RESIDENCE NO. 3827 Kate Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Levy

6 DATE OF BIRTH (month, day, and year) June 25th. 1885.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Levy,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Jenny Putzel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) U.S.A.

14 Informant Mr. Arthur Levy,

(Address) Strathmore Ave.

15 Filed ..... 19 ..... - 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to his death (autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull (Clin.)

(duration) Shock yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Slades M. D.

(Coroner)

4/27 (Address) 143 N. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cemetery Date of Burial June 5, 1927

20 UNDERTAKER David Londheim ADDRESS 118-20 W. Mt. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22845

CERTIFICATE OF DEATH.

E 22845

1-PLACE OF DEATH

Registered No. 10-14 100-001

City of BALTIMORE: (No. 817 Eutaw St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Little Ford

(a) Residence No. 817 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE Negro

5-Single, Married, Widowed, or Divorced. (Write the word.) X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 15, 1926.

7-AGE, yrs. 6 mos. 18 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. (State or Country) Md.

PARENTS.

10-NAME OF FATHER, Thomas Ford

11-BIRTHPLACE OF FATHER (city or town) Atlanta (State or Country) Georgia

12-MAIDEN NAME OF MOTHER, Elsie Campbell

13-BIRTHPLACE OF MOTHER (city or town) Washington (State or Country) D.C.

14- (Informant) Elsie Ford

(Address) 837 Harford Ave

15- 6 - 1927 C. HAMPSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3, 1927.

17- I HEREBY CERTIFY, That I attended deceased from May 1 1927 to June 3 1927.

that I last saw h alive on June 1, 1927.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) John R. Fitch M. D.

6/4, 1927 (Address) 936 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Astor Cemetery — DATE OF BURIAL, June 6, 1927

20-UNDERTAKER, Jos. T. Hitch — ADDRESS Rochester 1443 Jefferson

E 22846

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22846

CERTIFICATE OF DEATH.

188-03

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklyn Sq. Hosp. Ward 51)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter N. Pasquoche

(Residence in Baltimore: No. 2233 Huntingdon Ave. Street mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write which): Married

6-DATE OF BIRTH: July (Month) 5 (Day) 1898 (Year)

7-AGE: 21 yrs. 10 mos. 28 ds.

If LESS than 1 day, ...hrs. or... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Schauffer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS

10-NAME OF FATHER: Daniel Pasquoche

11-BIRTHPLACE OF FATHER, (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Rose Le Rose

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Pasquoche

(Address) 2233 Huntingdon Ave

15-

Filed ... 192...

Per ... Registrar.

C. HAMPSON JONES, M. D. - 1927

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 3rd (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Rup't Liver
Crushing auto injuries
(Duration) ... yrs. ... mos. ... ds. 1 hr.
CONTRIBUTORY
Lacerations over abdomen

(Signed) Thos. B. Norton M. D.
Coroner
June 5th 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: St Vincent

DATE OF BURIAL: June 6 1927

UNDERTAKER: A. S. Marshall

ADDRESS: 3539 Fall Rd

Spec.–7-17-26—A Co.—200 Bks.

E 22847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x60-002

E 22847

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Woman's Hospital St. W-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah K. Updegraff

(a) RESIDENCE NO. Prospect Street St. Ward Hagerstown, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Wm. M. Updegraff.

6 DATE OF BIRTH (month, day, and year): February 6, 1867.

7 AGE — Years: 60 Months: 4 Days: 29 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Johnstown, (State or country) Pa.

PARENTS

10 NAME OF FATHER: C. L. Keefer.

11 BIRTHPLACE OF FATHER (City or town): (State or country) Washington Co, Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Harbaugh

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Johnstown, Pa

14 Informant: Mr. William M. Updegraff

(Address) 183 S. Prospect St, Hagerstown, Md

15 Filed JUN 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per J.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June. 5, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to June 5, 1927, that I last saw her alive on June 5, 1927, and that death occurred, on the date stated above, at 2.42 P m.

The CAUSE OF DEATH* was as follows:

Adenoma of Thyroid.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical examination

(Signed) Wm. M. Wilson, M. D.

. 19 (Address) Women's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Date of Burial May 9 1927

20 UNDERTAKER: C. R. Coldsmith ADDRESS Hagerstown Md.

Very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22848 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22848

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1331 Division St., 17-24 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Frank

(a) Residence No. 1331 Division St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Frank

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
64 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chef Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Hanover Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Bertha Frank
(Address) 1331 Division St

15- Filed ..... 193.. C. HAMPSON JONES, M. D. Registrar.
JUN 15 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3. 1927

17- I HEREBY CERTIFY, That I attended deceased from May 25 1927 to June 3 1927 that I last saw him alive on June 3 1927 and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) — yrs. 8 mos. — ds

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Peltzman M. D
6/6/27 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	June 6 19 27
20-UNDERTAKER. Samuel P. Hemsley	ADDRESS 678 N Bridle

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22849

CERTIFICATE OF DEATH

49

E 22849

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St., 20-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Henry Elbury Pryor

(a) RESIDENCE NO. 2918 Fordham Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Henry Pryor

6 DATE OF BIRTH (month, day, and year) July 14 1893

7 AGE	Years	Months	Days 19	IF LESS than 1 day hrs. or min.
	33	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) U S Government

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Henry E Pryor

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Forest

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hall Records

(Address)

15 Filed JUN 6 - 1927 C. HAMPSON JONES, M. D. Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to June 3, 1927, that I last saw h i m alive on June 3, 1927 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Testicle

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Metastasis to Lungs

(duration) yrs. 2 mos ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Raymond I Johnston, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

Date of Burial 6/7 1927

20 UNDERTAKER J. F. Moran

ADDRESS 3000 E Baltimore

Very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22850

CERTIFICATE OF DEATH.

170 E 22850

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 1175

CITY OF BALTIMORE; (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archibald Russell Dennis

(a) RESIDENCE NO Latrobe Apts ST., Charles ward Rd

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Owings

6 DATE OF BIRTH (month, day, and year) June 28 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grain Commission
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co
(State or country) Md

10 NAME OF FATHER Geo R. Dennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset Co Md.

12 MAIDEN NAME OF MOTHER Fanny McPherson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Frederick Co Md

Informant Murdoch Dennis
(Address) 392 S. Univerity Ave.

Filed ..... 192 .....
Registrar

C. HAMPSON JONES, M. D.

1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Throat & Head.
Suicide
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison, M. D.
(Coroner.)
6/4, 1927 (Address) 362 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem Balto Md.	June 6 1927
20 UNDERTAKER	**ADDRESS**
Henry H. Jenkins Sons Co	McCulloh St.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 22851

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1024 McDonough St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Byrnes

(a) Residence No. 1024 McDonagh St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie F. Byrnes

6-DATE OF BIRTH (month, day and year): March 18-1865

7-AGE: 62 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Dry Dock Co.

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Joseph W. Byrnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Brigit O'Hara

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-

(Informant): Nellie F. Byrnes

(Address): 1024 McDonough St.

15-

Filed JUN 6 1927

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6-4-27

17- I HEREBY CERTIFY, That I attended deceased from 4-1 1927 to 6-4 1927

that I last saw him alive on 6-4 1927

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 3 ds

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Miller M. D.

6-5, 1927 (Address) 1500 A Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem DATE OF BURIAL: June 7 1927

20-UNDERTAKER: George W. Zinkler ADDRESS: 1737 E Eager St

Spec.—1-12-23—M&T—500 Blks.

E 22852 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3517 Ash St. ST., 13 WARD) 13-52 162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlin Melvin Kilby

(a) RESIDENCE No. 3517 Ash St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carlin F. Kilby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Macey Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Carlin F. Kilby
(Address) 3517 Ash St.

15 Filed ..... 19.. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927 to June 4 1927

that I last saw him alive on June 4 1927

and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

Acute Endocarditis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. F. Jones M. D.

June 6 1927 (Address) New Town - Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	June 6 1927
UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22853

CERTIFICATE OF DEATH.

90 E 22853

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 11-24 REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bailey

(a) RESIDENCE NO. 243 Canal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant [redacted]

(Address) [redacted]

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to June 4, 1927, that I last saw alive on June 3, 1927, and that death occurred, on the date stated above, at 6:25 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Myocardial hypertrophy and insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? N.D. Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Lynch M. D.

June 4 1927 Address BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial June 6 1927

20 UNDERTAKER Daniel Easton ADDRESS 716 Cathedral.

Spec.-7-17-26—A Co.--200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22854

E 22854

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Camilla Burroughs

(a) RESIDENCE NO. 914 W. Fayette st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Burroughs

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic. 01

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Wm. Harrington

11 BIRTHPLACE OF FATHER (City or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Eliza Small

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed JUN 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 13 19 27 to June 2 19 27

that I last saw her alive on June 2 19 27

and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W E Gatlin M. D.

6-3-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial June 6 19 27

20 UNDERTAKER Daniel Easton ADDRESS 916 Eu ave

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22855

1927

E 22855

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Roberts

(a) RESIDENCE NO. 758 George St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Herbert Roberts

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Jacob Long

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Long

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Barry Run Road

(Address)

15 Filed 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927 to June 4, 1927

that I last saw her alive on June 4, 1927

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Fracture neck Right Femur, (Shortened over 4 Inches Involved in Hip Joint).

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Peterson M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. June 6/27 Date of Burial

20 UNDERTAKER Daniel Easton ADDRESS 916 Gay

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22856
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

76 E 22856
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3626 Maple Ave. St., 13-57 Ward)

2-FULL NAME Fredericka May Frank.

(a) RESIDENCE No. 3626 Maple Ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William W. Frank.

6 DATE OF BIRTH (month, day, and year) Dec 25 1887.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Thomas Fouble.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Carrie L. Stigen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant William W. Frank.
(Address) 3626 Maple Ave.

15 Filed ..... 19..... Registrar .....

NO 1927 HAMPSON JONES, M. D.
Per RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1927.

17 I HEREBY CERTIFY, That I attended deceased from ....., 1927, to June 4, 1927,

that I last saw her alive on June 4, 1927,

and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

General Paresis, and
acute Myocarditis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? General paralysis of legs & arms.

(Signed) Chas H. Phillips M.D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Carroll Co.

DATE OF BURIAL June 7, 1927

20 UNDERTAKER Chenowith Son.

ADDRESS 3615 Eastern ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22857

CERTIFICATE OF DEATH

11-002

E 22857

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 N. Milton Ave St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Ritter

(a) RESIDENCE NO. 1109 N. Milton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C. Ritter

6 DATE OF BIRTH (month, day, and year): April 26, 1864

7 AGE: Years 63 Months 1 Days 8 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Charles P. Ritter

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary K Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary C. Ritter

(Address): 1109 N. Milton Ave

15 Filed ....., 19.... Per ..... Registrar

C. EMPSON JONES, M. D.

6 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-4-27

17 I HEREBY CERTIFY, That I attended deceased from 5-20, 1927 to 6-4, 1927 that I last saw h... alive on 6-4, 1927 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Influenza Pericarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted: unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? pending

(Signed) Edward Runyan M. D.

6, 19 27 (Address) 1800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 6 | 7 1927

20 UNDERTAKER: George J. Ruth ADDRESS 1785 Harford ave

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 22858

E 22858

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1062 E Pleasant ST. 4-7 (WARD)

2-FULL NAME Lavinia Babe

(a) RESIDENCE NO. 1062 E Pleasant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Dec 30 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): King William Co Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): King William Co Va

12 MAIDEN NAME OF MOTHER: Beverley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): King William Co Va

14 Informant: Samuel Beverly (Address) 1062 E Pleasant St

15 Filed [illegible], 1927 Per [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1927, to June 3rd 1927.

that I last saw her alive on June 3rd 27.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Val Dis of Heart (Mitral)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Rheumatism Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms, Autopsy

(Signed) [illegible], M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: King William Co Va

DATE OF BURIAL: June 7 1927

UNDERTAKER: Eugene Waters

ADDRESS: 423 N Fremont St

Spec.—12-9-25—A Co.—200 Bks.

E 22859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 22859

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 22-30

REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Oliver Buckler

(a) RESIDENCE NO. 107 W. Barre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Blanche Buckler (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31. 1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Henry Buckler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER — Cochran

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS Records

(Address)

15 Filed JUN 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 4, 1927, that I last saw him alive on June 3, 1927, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocardial Hypertrophy and Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? general laboratory

(Signed) J. Hampson Jones M.D.

June 4 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Station Date of Burial June 6 1927

20 UNDERTAKER E. Schloman & Son ADDRESS 1039 Lanvale

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22860

CERTIFICATE OF DEATH.

123

E 22860

REGISTERED NO.

1-PLACE OF DEATH The Church Home & Infirmary

City of BALTIMORE: (No. ____ St., 19-27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carolyn Smith (Caroline A. Mitchell Smith)

(a) RESIDENCE NO. 1606 West Baltimore St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Smith

6 DATE OF BIRTH (month, day, and year) January 7 1842

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	85	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Paint Store

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Mitchell

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Cole

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Maryland

14 Informant Eutha Mitchell Guerke

(Address) 3810 Chatham Road

15 Filed JUN 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 27 to June 4 19 27,

that I last saw h.er alive on June 4 19 27,

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY ____

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? Yes Date of June 1, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Harry C. Wilson, Jr. M.D., M. D.

, 19 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial June 7 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 22861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22861

1-PLACE OF DEATH

City of BALTIMORE: (No.) 238 N. Arlington Ave (Ward) 18-26

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Collins

(a) RESIDENCE NO. 238 N. Arlington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female 4 Color or Race: Mole Cold 5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3rd 1879

7 AGE: Years 47 Months 10 Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Julius White

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Ellen Brackett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Alice Collins (Address) 238 N Arlington Ave

15 Filed 16 1927 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd, 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 2 hours

CONTRIBUTORY (Secondary) Heart dilatation heart

(duration)

(Signed) Thos. B. Norris M. D.

(Coroner)

June 3rd, 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gins Cemetery Date of Burial 6/6/1927

20 UNDERTAKER Mrs Kate R Williams ADDRESS 322 N. Schroeder St.

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22862 (90)

E 22862 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3314 T. Fleet St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret D. Le Brun.

(a) RESIDENCE NO. 3314 T. Fleet St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Joseph A. Le Brun

6 DATE OF BIRTH (month, day, and year) Nov. 4th 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	76	7	29	

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Thos. Bradford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Delia Woods.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs Martin B Lackley (daughter)

(Address) 3314 T. Fleet St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Registrar

JUN 6 - 1927 Per R/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 1927, to 6/3, 1927

that I last saw h 4 alive on 6/2, 1927

and that death occurred, on the date stated above, at 11 00 a. m.

18 CAUSE OF DEATH* was as follows:

Chronic Myocarditis +

Arterio Sclerosis.

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? ..... Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. O'Connell, M. D.

(Address) 633-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

Date of Burial June 6th 1927

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4033 Wolfe St

Very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22863

CERTIFICATE OF DEATH.

E 22863

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1937 Ramsay St., 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Holland

(a) Residence No. 1937 Ramsay St., Ward.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Holland.

6-DATE OF BIRTH (month, day and year) Jan. 21 - 1876

7-AGE. 51 yrs. 5 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Gas Filling

(b) General nature of industry, business, or establishment in which employed (or employer). Station 508

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John R. Holland

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Howard Co. Md.

12-MAIDEN NAME OF MOTHER. Mary A. Colby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

11- (Informant) Margaret B. Holland

(Address) 1937 Ramsay St.

15- Filed JUN 5 - 1927 HAMPTON JONES, M. D. Registrar. Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 - 27

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926 to June 2, 1927

that I last saw him alive on June 2, 1927

and that death occurred, on the date stated above, at 10 45 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Apoplexy)

Arteriosclerosis Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Rheumatic

Ordered (Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Norval C. Kutsch M. D.

6/4, 1927 (Address) 2151 Wilkens Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery DATE OF BURIAL. June 5, 1927

20-UNDERTAKER. George L. Schwab. ADDRESS 1017 Druid Park Ave.

Spec.–7-17-26—A Co.—200 Bks.

E 22864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 22864

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1019 Hollins St. St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Maloney

(a) RESIDENCE NO. 1024 Boyd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Franklintown

(State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Maloney

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Neroell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant John J. Maloney

(Address) 1024 Boyd St.

15 Filed 6-1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 4, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to June 4, 1927,

that I last saw her alive on June 3, 1927,

and that death occurred, on the date stated above, at 1.40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? 1024 Boyd St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urin Analysis Etc.

(Signed) C. Hampson Jones, M. D.

June 4 19 27 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

Date of Burial June 7 19 27

20 UNDERTAKER Jno B. Cook

ADDRESS 1002 W. Baltimore St.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22865 — REGISTERED NO. 129 E 22865

1-PLACE OF DEATH

City of BALTIMORE: (No. 2103 W. Lexington St., 70-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Ray Clark

(a) RESIDENCE NO. 2103 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin F. Clark

6 DATE OF BIRTH (month, day, and year) Dec 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At. Home

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Amos Ford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Irene Wilkson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Benjamin F. Clark

(Address) 2103 W. Lexington St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

Per KM

JUN 6 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb, 19 24 to June 3, 19 27

that I last saw her alive on June 3, 19 27

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

4 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma Convulsion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Test.

(Signed) Martin E Trichman M. D.

June 4 19 27 (Address) 2002 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial June 6 19 27

20 UNDERTAKER J. B. Cook

ADDRESS 1003 W. Baltimore St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 22866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St. 27-55 Ward)

E 22866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel V. Glaser

(a) RESIDENCE NO. 24 Rockwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Walter Glaser

6 DATE OF BIRTH (month, day, and year) June 28/1902

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
✓	24	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Freed

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Eve E. Lambert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Walter Glaser

(Address) 24 Rockwood Ave

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ds.

(Signed) J. H. Carter M. D.

(Coroner)

6/6/27 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cem.	6/6/27

20 UNDERTAKER Harry A. Wilson ADDRESS 1531 W. Franklin.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 22867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22867

CERTIFICATE OF DEATH.

129 v.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2547 McCulloh ST. 13-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Vaughan

(a) RESIDENCE NO. 2547 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Buxton Vaughan

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C (Littleton)

PARENTS

10 NAME OF FATHER Kit Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mildred Zoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Buxton Vaughan (Address) 2547 McCulloh St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to June 3, 1927, that I last saw her alive on June 3, 1927, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

, 19 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bet. Auburn Cem

DATE OF BURIAL 6/6 1927

20 UNDERTAKER Samuel T Kennedy

ADDRESS 778 N Bradford

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22868

CERTIFICATE OF DEATH.

119 E 22868

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 779 George St St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Johnson

(a) RESIDENCE NO. 779 George St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. 7 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. T. Johnson

6 DATE OF BIRTH (month, day, and year): Oct. 2-1877

7 AGE: Years 49; Months 8; Days 4; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Phoebus Va.

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Phoebus Va.

12 MAIDEN NAME OF MOTHER Fannie Reed

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Phoebus Va.

14 Informant John Green (Husband)

(Address) 779 George St.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Apr June 3rd 1927

17

I HEREBY CERTIFY, That I attended deceased from May 30th. 1927 to June 3rd. 1927

that I last saw her alive on June 3th. 1927,

and that death occurred, on the date stated above, at 12.50p. M.

The CAUSE OF DEATH* was as follows:

Sepiscemiaxx

Septicemnia

(duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) Ischio-Rectal Abscess

(duration) .....yrs. 4 mos. 0? ds.

18 Where was disease contracted, if not at place of death? At place of death

Did an operation precede death? Yes Date of 5-30-'27

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ant Auburn Cem Date of Burial: June 6 1927

20 UNDERTAKER: Samuel T. Hemsley ADDRESS 378 Eddl

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22869

CERTIFICATE OF DEATH.

74-001

E 22869

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 1014 Ward)

2-FULL NAME Mary Grahasse

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Wm Gardner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Emily Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed JUN 6 1927 H. HAMPSON JONES, M. D. Registrar

By K M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

June 5th

17

I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h. Sd. alive on June 3, 1927,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Allamon, M. D.

June 5, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial June 6 1927

20 UNDERTAKER Rita Riedefeld ADDRESS 914 Fremont Ave

Very Important. See instructions on back of certificates.

Spec. 12-23-MCT-500 BF.

E 22870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22870

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 E Biddle ST. 10-14 WARD)

2-FULL NAME Thomas P. Dwirk

(a) RESIDENCE NO. 936 E Eager st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 2, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	62	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Dwirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Carrol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs J. Stanley Jacobs

(Address) 936 E Eager St

15 Filed JUN 6 - 1927 CLARENCE H. HARRISON-JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to June 5, 1927, that I last saw h alive on June 5, 1927, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff M. D.

6/6/1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross Cemetery Rd Hayes June 8, 1927

20 UNDERTAKER — ADDRESS

Ebner W. Conklin 924 E Eager st

Spec.—1-12-23—M&T—500 Bks.

E 22871

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22871

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 E. 23 St.; St., 9th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Miller

(a) RESIDENCE NO. 535 E. 23, St. St., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the Late Peter Miller

6 DATE OF BIRTH (month, day, and year) Dec 28, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
92 / 93		5	7 6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None in the Past

(b) General nature of industry, business, or establishment in which employed (or employer) O.D.

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Crownmiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Shipley Daughter (Address) 535 E 23 St

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1926, to June 4, 1927, that I last saw her alive on June 4, 1927, and that death occurred, on the date stated above, at 12 p m.

The CAUSE OF DEATH* was as follows:

Old age —

(duration) yrs. mos. Old ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Gardner, M. D.

6/7/1927 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. John Cemetery Long Green Md. June 8 1927

20 UNDERTAKER — ADDRESS

Elmer W. Conkelin 1427 E. Lagan St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22872

E 22872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 10-

CITY OF BALTIMORE: (No. 713 E. 20th St. ST.; 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Louise Cadwallader

(Residence in Baltimore: No. 713 E. 20th St. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 6, (Month) (Day) 1915. (Year)

7-AGE, 12 yrs. 2 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Maryland Md.

PARENTS.

10-NAME OF FATHER John A. Cadwallader

11-BIRTHPLACE OF FATHER (State or Country), West Va.

12-MAIDEN NAME OF MOTHER Cora Cessna

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Cadwallader

(Address) 713 E. 20th St.

15-

Filed ....., 192..... Registrar.

C. HAMPSON JONES, M. D.

6 - 1927 Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1927, to June 5 1927, that I saw h er alive on June 5 1927, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 wk. mos. ds.

CONTRIBUTORY (Secondary) Paralytic

(Duration) mos. ds.

(Signed) Edward C. Goodwin M.D.

June 6, 1927. (Address) 1506 N. Patterson Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, June 6, 1927.

20-UNDERTAKER Richard F. Curley

ADDRESS 2016 E. North Ave

Cor.—12-9-25—A Co.—200 Bks.

E 22873 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22873

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 S. Kenwood ave 4-3 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph David

(a) RESIDENCE NO. 1105 S. Kenwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angelia David

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	44	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER John David

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Goluch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Aby David. (Brother)

(Address) 1114 S. Streeper St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D.

JAN 6 - 1927 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

about (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Kenlon M. D.

(Coroner)

1927 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. - Date of Burial January 7 1927.

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22874 161-001 E 22874

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 W. Conn St. 21-31 Ward)

2-FULL NAME Baby Walden

(a) RESIDENCE NO. 421 W. Conn St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 4th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or 5 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ Col

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Walden

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Va.

12 MAIDEN NAME OF MOTHER Victoria Barom 6/14/27

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Va

14 Informant John Walden

(Address) 421 W. Conn St

15 Filed ....., 19 C. HAMPSON JONES, M. D.

1418 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 4 '27

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 4, 1927, that I last saw h.. alive on June 4, 1927, and that death occurred, on the date stated above, at 4.35 p. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery (6 mos)

..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Hampson Jones, M. D.

19 (Address) 901 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

JUN 6 - 1927

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Gutowska

E 22875

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 22875

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gestawska

(a) RESIDENCE NO. 823 S Port st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1863

7 AGE: 64 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant City Hospital

(Address)

15 6 - 7 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 5-31-, 1927, to 6-5-, 1927, that I last saw her alive on 6-5-, 1927 and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis Arteriosclerosis Cellulitis of Left Foot

(duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of 5-31-27

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — Date of Burial: June 8 1927

20 UNDERTAKER: George A. Weber — ADDRESS: 2205 Boston

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 22876

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22876

CERTIFICATE OF DEATH.

91-8

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 338 E. 36th ST., 12-49 WARD

2-FULL NAME Preston P. Keenan

(a) RESIDENCE NO. 338 E 36th ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Keenan

6 DATE OF BIRTH (month, day, and year) Jan 6-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70.	4	28 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James P Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Dunphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Keenan (Address) 338 E 36th St

15 Filed - 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4/27 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 2/26, 19 ..... to June 4/27, 19 .....

that I last saw him alive on June 4/27, 19 .....

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertrophy Heart

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Henry B Moll M. D.

June 5 19 27 (Address) 1 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 7 19 27

20 UNDERTAKER F. B. Hippert, 1850 W Baltimore

ADDRESS do

ec—12-23-21—E.B.R.S.—400 Bks.

E 22877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22877

CERTIFICATE OF DEATH.

61-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1154 Gorsuch Ave St., 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John Hamilton Wick

(a) Residence No.... 1154 Gorsuch Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 5/27

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day, 3 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John E. Wick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Selma A. Hamilton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Fayetteville No.

14- (Informant) John E. Wick

(Address) 1154 Gorsuch Ave

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 5/27

17- I HEREBY CERTIFY, That I attended deceased from June 5, 19 27 to June 5, 19 27

that I last saw him alive on June 5, 19 27

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical evidence

(Signed) Geo. B. Seybert, M. D.

, 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, June 6, 1927

20-UNDERTAKER, Mrs. Mrs. John K. Peeples & Son — ADDRESS 801 W. Fayette St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22878

CERTIFICATE OF DEATH.

E 22878

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Reynolds

(a) RESIDENCE NO. Upper Falls, Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 13, 1852

7 AGE: Years 74 | Months 11 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Reynolds

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Weems

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: Edward Reynolds

(Address) Upper Falls, Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1927, to June 4, 1927,

that I last saw her alive on June 4, 1927,

and that death occurred, on the date stated above, at 7.00 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Colostomy Date of Dec 9, 1926

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

June 4, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: June 7, 1927

20 UNDERTAKER: E. Leroy Stiffler — ADDRESS: 125 E. North ave.

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22879

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) Fayette (St.) (Ward) 21 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schaefer

(a) RESIDENCE NO. 1109 S Carey St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Rose Schaefer

6 DATE OF BIRTH (month, day, and year) Sept 27 1870

7 AGE: Years 56 Months 8 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spec Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mary'd Casualty Baltimore Md

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John F Schaefer

11 BIRTHPLACE OF FATHER (city or town) Balt Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah E Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balt Md (State or country)

14 Informant Rose D Schaefer (Address) 1109 S. Carey St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 1927 to June 4 1927, that I last saw him alive on June 4 1927, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH was as follows

Acute Nephritis

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Wallace Baker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 6 1927

20 UNDERTAKER William Cat Sons & Ennslin — ADDRESS

Please write very important. See instructions on back of certificate.

Spec.--7-17-26—A Co.—200 Bks.

E 22880

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22880

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Smith

(a) RESIDENCE NO. 2672 Lehmann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lizzie Smith

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE [redacted] Years 60 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 019

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Leo Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lenz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Lizzie Smith

(Address) 1639 W Lombard St

15 Filed 19

C. HAMPSON JONES, M. D. Registrar

Reg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-5-27

17 I HEREBY CERTIFY, That I attended deceased from 5-28 19 27 to 6-5 19 27

that I last saw h[redacted] alive on 6-[redacted] 19 27

and that death occurred, on the date stated above, at 2 40 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

Lung Abscess

(duration)

CONTRIBUTORY (Secondary) Bilateral Pneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-5-27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [redacted] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: June 8 '27

20 UNDERTAKER [redacted] — ADDRESS 500 E Monument

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 22881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 Fulton Ave ST., 15-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Vail Stephens.

(a) RESIDENCE NO. 2126 Fulton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~: widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: wm. A. Stephens

6 DATE OF BIRTH (month, day, and year): 1897

7 AGE: Years 36 (29 Yrs) Months Days If LESS than 1 day, hrs. or... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Thos Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Adelia Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Adelia Perry

(Address) 2126 N. Fulton Ave

Filed 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1927, to June 5, 1927, that I last saw h~~er~~ alive on June 4, 1927, and that death occurred, on the date stated above, at 12.25 m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of uterus with metastases

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Curettings.

(Signed) Hiram Fried M. D.

, 1927 (Address) 1010 St. Paul str.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: June 7 1927

20 UNDERTAKER: Wm Cook & Son

ADDRESS: E Balt

G. HAMPSON JONES, M.D.

Spec.–7-17-26—A Co.—200 Bks.

E 22882

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22882

CERTIFICATE OF DEATH

91-02

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1953 West Lexington St. Ward 10-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Sweet

(a) RESIDENCE NO. 1953 West Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph E. Sweet

6 DATE OF BIRTH (month, day, and year): 2-14-1847

7 AGE — Years: 80 Months: 3 Days: 20 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): England

14 Informant: Harry D. Sweet

(Address): 1953 W. Lexington

15 Filed ... 19... Registrar

1927 G. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 4 27

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1927 to June 4 1927

that I last saw her alive on June 4 1927

and that death occurred, on the date stated above, at 7 PM

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj. O. Williams, M. D.

4/6, 1927 (Address) 400 N Rayson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial 19

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22883

CERTIFICATE OF DEATH.

159-002

E 22883

1-PLACE OF DEATH 808 William st

CITY OF BALTIMORE: (No. ..... ST., 77-33 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mitchell

(a) RESIDENCE NO. 808 William ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-4-27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2 1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles W Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosalie Holyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rosalie Mitchell

(Address) 808 William St

15 Filed JUN 7 1927 C. HAMPSON JONES, M. D. Registrar

Par RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4 1927 to June 6 1927 that I last saw her alive on June 6 1927 and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Status Cerebralis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ... yrs. 6 hr mos. ... ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell, M. D.

6/6, 1927 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL June 7 1927

20 UNDERTAKER J. A. Strauss & Son — ADDRESS 703 Lamont St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 22884

CERTIFICATE OF DEATH.

90 **E 22884**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 N. Streeper St. 6-11 Ward)

2-FULL NAME Elizabeth C. Gritzner

(a) RESIDENCE NO. 12 N. Streeper St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Gritzner

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER August Lembach

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Hundt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Otto Gritzner

(Address) 12 N. Streeper St

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

By RRB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927 to June 3 1927, that I last saw h.. alive on June 3 1927, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Duration

Cardiac Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) O. Kent Insley M. D.

6-5 1927 (Address) 2358 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial June 7 1927

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS 1710 Fleet St.

Very Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

See Letter in File

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22885

CERTIFICATE OF DEATH.

90 E 22885

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1827 Lyndew St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theo. Bisesz

(a) RESIDENCE NO. 1827 Lyndew St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emilia Bisesz

6 DATE OF BIRTH (month, day, and year) Jan. 16-1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer of Lab

(b) General nature of industry, business, or establishment in which employed (or employer) Lawnmower

(c) Name of employer

9 BIRTHPLACE (city or town) Vienna

(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Emilia Bisesz

(Address) 1827 Lyndew

15 1927 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by said Inquest, and Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 1 yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 3 yrs. mos. ds.

June 6 1927 (Signed) G. C. Wades M. D.

(Coroner)

(Address) 143 W. Ray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park, Balt. Date of Burial June 7 1927

20 UNDERTAKER Harry W. Ellen ADDRESS W. North Ave

Very Important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22886

CERTIFICATE OF DEATH.

129 E 22886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp ST 25-72 WARD)

2-FULL NAME Julius Eichert

(a) RESIDENCE NO. 2430 Washington Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Conway Eichert

6 DATE OF BIRTH (month, day, and year) Oct 26 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Fredrick Eichert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Emma Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Mrs Mary Eichert

(Address) 2430 Washington Blvd

15 Filed JUN 9 1927 G. HAMPSON JONES, M. D. Registrar

By: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-31, 1927, to 6-4, 1927, that I last saw h[illegible] alive on 6-4, 1927, and that death occurred, on the date stated above, at 2 20 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. L. Dudaglaiser M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL June 9 1927

20 UNDERTAKER Margaret D. Flynn

ADDRESS 1402 Light

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22887

CERTIFICATE OF DEATH

90

REGISTERED NO. E 22887

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3900 Norfolk Ave. 5-58 Ward)

2-FULL NAME William H. Hawson

(a) RESIDENCE NO. 3900 Norfolk Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie A Hawson

6 DATE OF BIRTH (month, day, and year) Aug 30, 1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	79	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Baggage Master

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer B & O R R Co

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER William E. Hawson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Barbara Hawson

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Europe

14 Informant (Address) Mrs. Wm. H. Hawson 3900 Norfolk Ave

15 Filed ..... 19 ..... Registrar

1927 C. HAMPSON JONES, M. D.

Port 8th

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927 to June 4 1927.

that I last saw h i alive on June 4 1927.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardiac Insufficiency

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Hudelson M. D.

, 19 (Address) 823 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial June 7 1927

20 UNDERTAKER Margaret A. Flynn ADDRESS 1412 Light

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22888

CERTIFICATE OF DEATH.

129

E 22888

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 N. Stricker St. St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucella Jenifer

(a) RESIDENCE NO. 317 N. Stricker St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rasberry Jenifer

6 DATE OF BIRTH (month, day, and year): Unknown 1860

7 AGE: Years 67; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Jas. Taylor

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Sadonia Boom

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Calvert Co. Md.

14 Informant: Rev. Jas. J. Taylor

(Address): 1119 Divison St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JN 7 - 1927 by R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June, 5th. 1927

17

I HEREBY CERTIFY, That I attended deceased from March. 1st, 1927 to June 5th. 1927

that I last saw her alive on June 4th. 1927

and that death occurred, on the date stated above, at 10;40 a.m.

The CAUSE OF DEATH* was as follows:

Mitrel Ins.

(duration) yrs. 4. mos. 5 ds.

CONTRIBUTORY (Secondary) Ch. Interstital Neph.

(duration) yrs. 4. mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial June 8 1927

20 UNDERTAKER: John W. Toadvine ADDRESS 1027 Druid Hill

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1813 Little Wolfe St. (WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Rachel Gross

(a) RESIDENCE NO. 1813 Little Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Wesley Gross

6 DATE OF BIRTH (month, day, and year): Sept. 16, 1854

7 AGE: Years 72, Months 8, Days 20 / 18. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Has not worked for yrs.

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: James Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Henrietta Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant (Address): John Allen Gross 1807 N Mount St

15 Filed JUN 7 1927 C. HAMILTON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to June 4, 1927, that I last saw h— alive on June 2, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

Senility (duration) yrs. 3 mos dys

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W H Wright M. D.

1927 (Address) 1209 Professional

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn DATE OF BURIAL June 7 1927

20 UNDERTAKER: John N. Trader Funeral Home ADDRESS 1027

THIS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22890

CERTIFICATE OF DEATH

129

E 22890

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Provident Hospital St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Derry

(a) RESIDENCE NO. 1016 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Mathia Derry

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Martha Watts

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant Harrold Derry

(Address) 1016 Druid Hill

15 Filed JUN 7 - 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 1927 to June 4 1927

that I last saw him alive on June 3 1927

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic arterio-sclerosis & syphilis

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) John W. Garner M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial June 7 1927

20 UNDERTAKER Jos. H. Toadvine ADDRESS 1127 Druid Hill

very important. See instructions on back of certificates.

✓ 161-001 E 22891

1 PLACE OF DEATH
E 22891

County

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City Baltimore (No. 821, S. Ellwood Ave, St. / Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME 4 month Embryo (Gallagher)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: May (Month) 30 (Day) 1927 (Year)

7 AGE: yrs. mos. ds. | If LESS than 1 day, / hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Gallagher

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes McDonnald

13 BIRTHPLACE OF MOTHER (State or country) New Port Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Agnes Gallagher

(Address) 821 S. Ellwood Ave

15 Filed 1927 (191) HAMPSON JONES, M. D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 30 (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to May 30, 1927, that I last saw him alive on May 30, 1927, and that death occurred on the date stated above, at 11.30 m.

The CAUSE OF DEATH * was as follows:

4 month Embryo

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Horace B. Fellow M. D.

June 6 1927 (Address) 315 S. Highlandtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Johns Hopkins Embryo Dept	May 31, 1927
20 UNDERTAKER	ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22892 — 1-PLACE OF DEATH

129 E 22892 — REGISTERED NO.

City of BALTIMORE: (No. 816 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine A. Gilleard.

(a) RESIDENCE NO. 816 S. Robinson St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. X mos. X ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Thomas Gilleard

6 DATE OF BIRTH (month, day, and year) Nov. 3rd 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	69	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md. (State or country)

PARENTS

10 NAME OF FATHER Bernard Dunnigan

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bessie Filzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Bernard J. Gilleard

(Address) 816 S. Robinson St.

15 Filed ....., 19 .....

1 - 1927 C. HAMP[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1927, to June 4, 1927, that I last saw her alive on June 4, 1927, and that death occurred, on the date stated above, at 11.55 p. m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

chr. nephritis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Joseph Forster M. D.

. 19 (Address) 508 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — Date of Burial June 8th 1927

20 UNDERTAKER Lilly - Zeller — ADDRESS 403 S Wolfe St

very important. See instructions on back of certificates. — 7 — OCCUPATION IS

Spec.—12-9-25—A Co.—200 Bks.

Hoover

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 22893
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 22893
REGISTERED NO.

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hoover

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Oliver H. Hoover.

6 DATE OF BIRTH (month, day, and year) about 1851

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about 76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John McManus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Flynn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed ..... 19..... H. M. JONES, M. D.

Registrar

JN 1 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from No record 19..... to June 2nd 1927, that I last saw h.... alive on June 2nd 1927, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ..... yrs. ..... mos. 2 wks. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

June 4, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Patrick's Cemetery June 7th 1927

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Woll St

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22894

CERTIFICATE OF DEATH

90

REGISTERED NO. E 22894

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 S. Regester St 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Sletzer

(a) RESIDENCE NO. 417 S. Regester St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Sletzer.

6 DATE OF BIRTH (month, day, and year): Jan 5th 1863

7 AGE: Years 64 Months 4 Days 28 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General natore of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER: John Sletzer

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont Kubur

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant (Address): Josephine Sletzer (Wife) 417 S. Regester St.

Filed ... 19... Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from April 25 1927 to June 3 1927

that I last saw him alive on June 3 1927

and that death occurred, on the date stated above, at 11-10 A. M.

The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas Green, M. D.

6/4/27, 19 (Address) 408 S Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: June 7th 1927

20 UNDERTAKER: Lilly + Zeiler — ADDRESS 4033 Wolfe St

very important. See instructions on back of certificates.

JUN 7 - 1927 HAMILTON JONES, M. D.

Spec.-7-17-26—A Co.—200 Bks.

E 22895

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22895

905

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (Wallace Ave & Carroll Road St. 27-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Weikel

(a) RESIDENCE NO. Wallace Ave & Carroll Road St. Ward Raident
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 6 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 74 yrs. 6 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Weikel

6 DATE OF BIRTH (month, day, and year) Nov. 19 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Weikel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Scherer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs, Helen Weikel (Wife)

(Address) Wallace Ave & Carroll Road.

15 Filed JUN 7 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1926, to June 4, 1927, that I last saw him alive on June 4, 1927, and that death occurred, on the data stated above, at 11.35 P m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? ---

Did an operation precede death? Data of

Was there an autopsy? No

What test confirmed diagnosis? Diagnosed by Coroner

(Signed) Chas F Weikel, M. D.

6/5/ 1927 (Address) 27 W Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial June 7 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOSER, Successor) — ADDRESS 108 W. NORTH AVE.

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 22896

1-PLACE OF DEATH

CERTIFICATE OF DEATH

25-65

REGISTERED NO. E 22896

City of BALTIMORE: (No. Franklin Road Franklintown 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Gohr

(a) RESIDENCE NO. Franklin Rd. Franklintown Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella A. Gohr

6 DATE OF BIRTH (month, day, and year) Jan. 5. 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	55	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinand Gohr

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Ella A. Gohr

(Address) Franklintown, Md.

15 Filed JUN 7 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R. K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 31st 1927 to June 5th 1927

that I last saw h[illegible] alive on June 5 1927

and that death occurred, on the date stated above, at 10.40 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bronchopneumonia Influenza

(Signed) C. C. Smith M. D.

June 6 1927 (Address) 4309 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery — Date of Burial June 9 1927

20 UNDERTAKER John F. Denny — ADDRESS 716 Light St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22897 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22897

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 8-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline J Rehbein

(a) RESIDENCE No. 1129 N. Milton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15=1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	21. 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Andrew Rehbein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bertha L Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Andrew Rehbein

(Address) 1129 N Milton Ave

15 Filed JUN 7 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1927, to June 5th, 1927,

that I last saw h alive on June 5th, 1927

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Acute purulent Otitis media

Broncho-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Jacob Rosenow M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL June 8 1927

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

R.K.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22898 + 90 **E 22898**

CERTIFICATE OF DEATH.

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. (Ward)

2-FULL NAME George [redacted] Fisher

(a) RESIDENCE NO. 1 Hall Ave., Essex St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Fisher

6 DATE OF BIRTH (month, day, and year) August 22 1869.

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
57	4-22-1869	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motor Tender

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Fisher

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Annie Trenks June 5. 1927

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed JUN 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-5-27

17

I HEREBY CERTIFY, That I attended deceased from 4-25-27 19 to 6-5-27, 19

that I last saw h. alive on 6-4-27, 19

and that death occurred, on the date stated above, at 6:40A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arteriosclerosis Fibrillation

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? General Clinical Facts

(Signed) R. Hoffman Smith, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial June 8 1927

20 UNDERTAKER John Merrick ADDRESS 2208 Erdman St

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22899
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

E 22899

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Wasson

(a) RESIDENCE NO. Salisbury N. C. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

3a If married, widowed, or divorced BUSBAND of (or) WIFE of Lanca

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) D?

(c) Name of employer

9 BIRTHPLACE (city or town) N. Car.

(State or country)

PARENTS

10 NAME OF FATHER R. L. Wasson

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country) N Car

12 MAIDEN NAME OF MOTHER Lina Hines

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Records.

15 Filed ____ 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1927, to June 6th, 1927, that I last saw him alive on June 6th, 1927, and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ....yrs. ....mos. 3 ds.

CONTRIBITORY (Secondary) Pulmonary oedema

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 6/3/27.

Was there an autopsy? Yes

What test confirmed diagnosis? Exploratory - Operation & autopsy

(Signed) George G. Finney, M. D.

(Address) June 6th 1927 Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury N C — Date of Burial: 6/7/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bay

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+43

E 22900 CERTIFICATE OF DEATH

E 22900 REGISTERED NO.

CITY OF BALTIMORE: (No. Howard R. Kelly Hospital ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kimball Ziegfeld

(a) RESIDENCE No. 1418 Eutaw Place ST., WARD Chicago Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Ziegfeld

6 DATE OF BIRTH (month, day, and year) Oct 21 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prof Chicago Musical College

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago Ill

PARENTS

10 NAME OF FATHER Dr Florenz Ziegfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bremen Germany

12 MAIDEN NAME OF MOTHER Rosalie Dehez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Paris France

14 Informant Florenz Ziegfeld (Address) Hotel Lenox

15 Filed JUN 7 - 1927 19 per R.P.C. Registrar

C. HAMPTON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to June 6, 1927, that I last saw h[illegible] alive on June 6, 1927, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the tongue
Metastasis to glands of neck

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) same as above.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know.

Did an operation precede death? yes Date of Feb 9. 1926.

Was there an autopsy? No.

What test confirmed diagnosis? Microscope.

(Signed) Thurlow Nevil Dr M. D.

6-7, 1927 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill — DATE OF BURIAL June 7 1927

20 UNDERTAKER Chas. S. Black — ADDRESS 742 W Lexington ave

Spec.—12-9-25—A Co.—200 Bks.

E 22901

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22901

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 7-9

REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Haban

(a) RESIDENCE NO. Waxter Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28. 1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	16	2	13 8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Adolph Haban

11 BIRTHPLACE OF FATHER (city or town) Ger
(State or country)

12 MAIDEN NAME OF MOTHER Eliz - Halter

13 BIRTHPLACE OF MOTHER (city or town) Eng
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Woods -

15 Filed 1 - 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4 1927, to June 6, 1927, that I last saw h.. alive on June 6, 1927, and that death occurred, on the date stated above, at 1 2 9 m.

The CAUSE OF DEATH* was as follows: Puerperal Pneumonia, lobular (Post-operative aspiration)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Difficult labor - forceps delivery - ether anaesthesia

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? Yes Date of June 5, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. K. Boerner, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 9 1927

20 UNDERTAKER Edwin Cook - Sons & Lundy ADDRESS

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22902

CERTIFICATE OF DEATH.

90 E 22902

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 735 E. North St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Helen Davenport.

(a) RESIDENCE NO. 735 E. North St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

5a If married, widowed, or divorced (or) WIFE of Archer B. Davenport

6 DATE OF BIRTH (month, day, and year) Unknown — 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Robert Sowers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Archer B. Davenport

(Address) 735 E. North Ave

15 Filed June 7 19 27 C. HAMPSON JONES, M. D.

No. 7 - 1927 Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows

Mitral Stenosis

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary) Cellulitis

(duration) yrs. mos. 1 ds.

June 7 19 27 (Signed) G. C. Hadis M. D. (Coroner)

(Address) 143 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. Richmond Va. Date of Burial 6/8 19 27

20 UNDERTAKER Watts Bros. ADDRESS 330 Park St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22903 | 11 E 22903

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen B. Jones

(a) RESIDENCE NO. 141 N. Eutaw Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and state) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	56	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seamstress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. D. Jones

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen C —

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant [redacted]

(Address) [redacted]

15 Filed ..... 19.. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1927, to June 6, 1927.

that I last saw h[illegible] alive on June 6, 1927.

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Ruptured Appendix

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gen'l & Laboratory

(Signed) H. H. Kerr Jones M. D.

June 5 '27 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Cemetery	June 7 1927
20 UNDERTAKER	ADDRESS
Mrs. E. Miller & Son	2334 Eutaw Pl.

very important. See instructions on back of certificates. | CAUSE OF DEATH | PLACE OF BURIAL | NAME OF UNDERTAKER

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 22904

CERTIFICATE OF DEATH.

E 22904

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Olive St., 9-17 Ward)

2-FULL NAME Barthlomew Morton Jr.

(a) RESIDENCE NO. 1407 Olive st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jun 5-1927

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or 4 min.
			+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Barthlomew Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna. Richil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Morton
(Address) 1407 Olive

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Jun 5, 1927, to Jun 6, 1927,

that I last saw h~~e~~ alive on Jun 5, 1927

and that death occurred, on the date stated above, at 6-10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(6 Mo 2 weeks Gestation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Enbarelin

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. E. Langbein, M. D.

Jun 6, 1927 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laudu Hill — DATE OF BURIAL 6/8/27

20 UNDERTAKER J. Fenw McCauley — ADDRESS 130 E. Fort

Spec.—12-9-25—A Co.—200 Bks.

2 AB 22905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22905
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ____ St. 23-24 Ward)

2-FULL NAME Sewell Horstmen

(a) RESIDENCE NO. 1618 Patapsco St. ____ Ward ____
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Child

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1926

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	9 8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Sewell Horstman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Frank

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JUN 7 - 1927 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1927, to June 6th, 1927, that I last saw h.l.v. alive on June 6, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.
, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leaden Hill Date of Burial 6/8 1927

20 UNDERTAKER J. F. McCully ADDRESS 128 E. Fod

N. B. Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22906

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 E Biddle ST. 10-14 WARD) 32

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E Spalin

(a) RESIDENCE NO. 1218 E Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles H. Spalin

6 DATE OF BIRTH (month, day, and year) Aug 4 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry C. Denhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Rodemaya

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Charles H. Spalin

(Address) 1218 E Biddle St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/30, 1927, to 6/6, 1927, that I last saw h alive on 6/6, 1927, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Basilar Meningitis

(duration) yrs. mos 8 ds

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Double Lobar Pneumonia of Upper Lobe of Left Lung

What test confirmed diagnosis? Basilar Meningitis

(Signed) D Bernard Gorter, M. D

6-7-1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL June 10 1927

20 UNDERTAKER Henry Hoark Son ADDRESS 1301 E Eager St

IT IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

...TON H. JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22907

CERTIFICATE OF DEATH.

161-001

E 22907

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3431 Ash St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Charles H. & Annie B. Taylor

(a) RESIDENCE NO. 3431 Ash St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6-1927

7 AGE Years Months Days | If LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles H. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie B. Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles H. Taylor

(Address) 3431 Ash St.

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 6, 1927, that I last saw h alive on June 6, 1927, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth
6½ months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. J Davis, M. D.

6. 7. 1927 (Address) 800 N 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Marys Hampden — DATE OF BURIAL: June 7-1927

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Road

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22908 101-001 E 22908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: City of BALTIMORE: (No.) W. B. Gen'l Hosp. (St.) 15-63 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howell Milliken

(a) RESIDENCE NO. 3912 Liberty Heights St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Virginia Milliken

6 DATE OF BIRTH (month, day, and year) July 27/1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rollins J. Milliken

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Grace McNeal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Grace Milliken

(Address) 1409 W. Lanvale St. Balto. Md

15 Filed June 9 1927 H. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) Acute Cardiac Dil— yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

June 6 (Signed) C. C. Yates M. D.

1927 (Coroner)

(Address) 1436 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial: June 8 1927

20 UNDERTAKER: Chas. E. Franck ADDRESS: 201 Madison Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 V

E 22909

CERTIFICATE OF DEATH.

E 22909
REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 857 W. Fayette St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Pickering

(a) RESIDENCE NO. 857 W. Fayette St. St. _____ Ward Annapolis Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ or ~~WIFE of~~ Wife of William Pickering

6 DATE OF BIRTH (month, day, and year) Dec 5th 1877

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
49	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER James A. Hardesty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Anna Rebecka Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annapolis Md.

14 Informant Mrs. Wilbur A. Kirby

(Address) 857 W. Fayette St.

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

JUN 7 - 1927 Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/27

17

I HEREBY CERTIFY, That I attended deceased from 6/4, 1927, to 6/5/27, 19____,

that I last saw h.. alive on 6/5/27, 19____,

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Probably Ch. Int Nephr.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) _____ yrs. _____ mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Wassermann (Neurosyphilis)

(Signed) Bernard A. Fenz, M. D.

6/6, 1927 (Address) 910 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial June 8th 1927

20 UNDERTAKER Wilbur W. Shriver ADDRESS 1018 Edmondson Ave.

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22910

CERTIFICATE OF DEATH

E 22910

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1503 N. Fremont St. Ward 15-21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Lenie Cummings

(a) RESIDENCE NO. 1503 N. Fremont St. Ward 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: David Andrew Cummings

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49 Months — Days — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) ... (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) ... (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) —

14 Informant (Address) David A. Cummings 1503 N. Fremont

C. HAMPTON JONES, M. D.

15 Filed JUN 7 - 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1927, to June 6th, 1927, that I last saw her alive on June 6th, 1927, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

15 to 20 hrs.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) A. E. Fell M. D.

6 6, 1927 (Address) 1503 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial June 8 1927

20 UNDERTAKER: Wm. H. Case & Son — ADDRESS 1400 Mosher

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22911

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22911

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Division ST. 14-20 WARD)

2-FULL NAME Tyson & Boston

(a) RESIDENCE NO. 1616 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Boston.

6 DATE OF BIRTH (month, day, and year) Sept 24 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public (Caterer) Wap Lucky Inlay Island

9 BIRTHPLACE (city or town) (State or country) West River Md.

PARENTS

10 NAME OF FATHER Daniel Boston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Md

12 MAIDEN NAME OF MOTHER Louisa Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River

14 Informant Mary Boston. (Address) 1616 Division St.

15 Filed 6/4 1927 G. HAMPSON JONES, M. D. Registrar Per PKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2 1927 to June 4 1927 that I last saw h alive on June 4 1927 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation Superduced by Acute Gastritis

(duration) hrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Et (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Blood Pressure

(Signed) Thos. G. Hampson M.D.

6/4, 1927 (Address) 1209 Presbman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/7/1927

20 UNDERTAKER Thos. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001

E 22912

CERTIFICATE OF DEATH.

E 22912

REGISTERED NO._____

1-PLACE OF DEATH Johns Hopkins Hospital

City of BALTIMORE: (No. _____ St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Forbes

(a) RESIDENCE NO. 1172 Druid Hill Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced: (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5, 1927

7 AGE: Years | Months | Days | IF LESS than 1 day 20 hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ____

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer

9 BIRTHPLACE (city or town): ____

(State or country) Md.

PARENTS

10 NAME OF FATHER: Ernest Forbes

11 BIRTHPLACE OF FATHER (city or town): ____

(State or country) Va.

12 MAIDEN NAME OF MOTHER: Viola L Gray

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country) Md.

14 Informant: Records

(Address) Johns Hopkins Hospital.

15 [illegible] 1927 C. H. [illegible] M. D. Registrar

1427 1224

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-5 1927, to 6-6, 1927

that I last saw him alive on 6-6, 1927

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ mos)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY — (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? ____

(Signed) J K Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

Date of Burial: 19

20 UNDERTAKER: Commissioner Health

ADDRESS

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22913 90 E 22913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Holmes

(a) RESIDENCE NO. [redacted] St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

10 NAME OF FATHER John Holmes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Elsie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

PARENTS

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Baltimore

15 Filed 19 1927 G. HAMPSON JONES, M. D. Registrar

1428

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17

I HEREBY CERTIFY, That I attended deceased from April 30 1927, to June 5 1927, that I last saw him alive on June 5, 1927, and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & insufficiency

(duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hampson Jones, M. D.

June 6 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND Baltimore JUN 7 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22914

CERTIFICATE OF DEATH

3/ E 22914

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 4420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard S. Bowen

(a) RESIDENCE NO. 1510 Eutaw Place. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) O.S.O

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Bowen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Burnham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

1429

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17 19 24 to June 3 19 27

that I last saw him alive on June 3 19 27

and that death occurred, on the date stated above, at 12.10 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W.S. Bowen M. D.

6-3-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial June 10/27 19

20 UNDERTAKER Geo. Cook & Son ADDRESS Eutaw

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22915 E 22915

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3006 St. Paul ST. 17-50 WARD

2-FULL NAME Bertha Reinhardt

(a) RESIDENCE NO. 3006 St. Paul ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan. 6-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	89	5	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 668

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?. Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Leichmullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Droggl (Address) 3006 St. Paul St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Put 1064

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1926 to June 6 1927, that I last saw her alive on June 5 1927 and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Fatty Degeneration

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Senile Gland Prostate

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. K. A. Mayer, M. D.

6/7, 1927 (Address) 2431 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~ CREMATION ~~OR REMOVAL~~ London Park DATE OF BURIAL June 8 1927

20 UNDERTAKER Wm J. Tickner & Son ADDRESS N. Ave Pa

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22916

E 22916

CERTIFICATE OF DEATH

1-PLACE OF DEATH Hospital for Women of Md. REGISTERED NO. 1927-20

City of BALTIMORE: (No. Lafayette ave. & John St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kathrine Tracue Worthington

(a) RESIDENCE NO. 1531 Bolton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellicott Worthington

6 DATE OF BIRTH (month, day, and year) July 4th 1875

7 AGE 51 Years 11 Months 3 Days 52

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.

(State or country)

PARENTS

10 NAME OF FATHER Geo. P. Frick.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Kathrine Turnbull

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mrs R. D. Frick

(Address) 1503 Bolton St

15 Filed 19 Registrar

1927 C. HAMPSON JONES, M. D.

Per R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1927, to June 7, 1927.

that I last saw her alive on June 7, 1927.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Peritoneal, carcinomatosis, primary in ovary.

(duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of June 4, 1927.

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Operation

(Signed) Wm. A. Lothrop, M. D.

(Address) June 7 1927. Woman's Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

Date of Burial: June 9 1927

20 UNDERTAKER: Henry W Jenkins & Co.

ADDRESS: Oliver and Bolton Sts

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22917

CERTIFICATE OF DEATH.

16-229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 N. Appleton ST., WARD)

2-FULL NAME William H. R. Gosnell

(a) RESIDENCE NO. 906 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Gosnell

6 DATE OF BIRTH (month, day, and year) May 6, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	[redacted]	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool Sharpener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Zumbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary R. Gosnell

(Address) 906 N. Appleton

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/2/ 1927, to 6/5/27, 19

that I last saw h— alive on 6/5/27, 19

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Ch. Diff. Hypertension

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? J. H. Hosp.

(Signed) Benj. J. Gray, M. D.

6/6/1927 (Address) 906 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Granite, Balto. Co.

DATE OF BURIAL June 8, 1927

20 UNDERTAKER E. Leroy Stiffler

ADDRESS 125 E. North Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 22918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22918

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 N. Kenwood ave ST. 6-11 WARD)

2-FULL NAME Elizabeth D. Michel

(a) RESIDENCE NO. 21 N. Kenwood ave ST. 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry G. Michel

6 DATE OF BIRTH (month, day, and year) May 4 - 1864

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
63	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Siegmund Baumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Geraldine Sybert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Henry G. Michel

(Address) 21 N. Kenwood ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19.., to June 5, 19..

that I last saw her alive on June 5, 19..

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Intest Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symp

(Signed) H. Mc Guday, M. D.

(Address) 2958 Gaul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 6/8/ 1927

20 UNDERTAKER J. A. Moran

ADDRESS 2200 E Baltimore

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22919

CERTIFICATE OF DEATH.

1295

E 22919

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1748 E. Preston St St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Pate

(a) RESIDENCE NO. 1748 E. Preston St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E. Pate

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sparrow's Point

9 BIRTHPLACE (city or town)

(State or country) Malto., Md.

PARENTS

10 NAME OF FATHER Josiah Pate

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant Mary E. Pate

(Address) 1748 E. Preston St

15 Filed 6/7/27, 19 C. HAMPTON JONES, M. D.

8 - 1927 By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis ?

(duration) yrs. mos. ds.

(Signed) J. S. Watson, M. D.

(Coroner)

6/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial June 9th 27

20 UNDERTAKER F. C. Wanner & Son ADDRESS 703 Hanover

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22920

CERTIFICATE OF DEATH.

E 22920

REGISTERED NO. [illegible]

1-PLACE OF DEATH

City of BALTIMORE: (No. Pine & Vine St. 4-25 Ward)

2-FULL NAME Sarah Owens

(a) RESIDENCE NO. 643 W. Balto St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Presley Owens

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 58 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Court Rinor

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Rinor

13 BIRTHPLACE OF MOTHER (city or town): Foot Rinor

(State or country)

14 Informant: Wilson Jenkins

(Address): Welcome Va

15 Filed ..... 19 .....

Per ..... Registrar

G. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident

Multiple Fractures

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

June 6 27 Signed G C Hades M. D.

(Coroner)

(Address) 1143 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredericksburg Date of Burial: June 8 1927

20 UNDERTAKER: Edw Toulson ADDRESS: 900 Woodlawn Ave

very important. See instructions on back of certificate.

NO 6 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 22921

CERTIFICATE OF DEATH.

E 22921

REGISTERED NO.

PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hospital St. 13-54 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Yetta Krieger

(a) RESIDENCE NO. 1314 W. Northern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Krieger

6 DATE OF BIRTH (month, day, and year): Uncertain

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Russo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Herman Krieger

(Address) 1314 W North Ave

15 Filed ..... 19 ..... C. HAMILTON JONES M. D. Registrar

8 - 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 6, 1927

I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to June 6, 1927, that I last saw h S.T. alive on June 6, 1927, and that death occurred, on the date stated above, at 6:00 A m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acute tonsilitis (Not Op left)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? (1) 5/14/27

Did an operation precede death? Yes Date of 2nd 5/21/27.

Was there an autopsy? No

What test confirmed diagnosis? Operation, Clinical Symptoms

(Signed) Louis Jacobs M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. Date of Burial: 6/8 19 27

20 UNDERTAKER: Jack Lewis ADDRESS: 1429 E Balt St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22922

CERTIFICATE OF DEATH.

E 22922

90

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 20-26 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Schaller (Schoeller)

(a) RESIDENCE NO. 1906 Mc Henry St. _____ Ward _____

(Usual place of abode) 2yr Know (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 56 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Single~~

6 DATE OF BIRTH (month, day, and year): Not Kn

7 AGE: About

Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
56	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: "

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF ~~FATHER~~ Charles Brunner

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md. Kn

14 Informant Charles Brunner

(Address) 1636 East Eager St

15 Filed NOV 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-7-27

17

I HEREBY CERTIFY, That I attended deceased from 6-3, 1927, to 6-7, 1927, that I last saw him alive on 6-7, 1927, and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ____ yrs. 4 mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? Physical findings

(Signed) Colin Brice, M. D.

, 1927 (Address) 8 E Eager St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: June 9 1927

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22923
1-PLACE OF DEATH

CERTIFICATE OF DEATH

Registered No. E 22923

City of BALTIMORE: (No. 924 Shields Place St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Davis

(a) Residence No. 924 Shields place St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Priscilla Davis

6-DATE OF BIRTH (month, day and year) Sept 1870

7-AGE, 57 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, Ship Caulker

(b) General nature of industry, business, or establishment in which employed (or employer), 615

(c) Name of employer,

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, George Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Sylvia Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant) Priscilla Davis

(Address) 924 Shields Place

15-

Filed JUN 8 - 1927 19?

G. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 5/27

17-

I HEREBY CERTIFY, That I attended deceased from April 2 1927, to June 5 1927, that I last saw h living on June 5 1927, and that death occurred, on the date stated above, at 10:30 a.m. p.m.

The CAUSE OF DEATH was as follows:

Nephritis

Chron

(Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) 0

(Duration) 0 yrs. ds.

18-Where was disease contracted if not at place of death? 924 Shields Pl

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Albuman, Casts

(Signed) John C. Stewart M. D.

, 19 (Address) 724 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn DATE OF BURIAL, June 8 19 27

20-UNDERTAKER, Barnes & Wilhelm ADDRESS 364 W Fayette

Spec.—12-9-25—A Co.—200 Bks.

1998 E 22924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St., 16-23 Ward)

REGISTERED NO. 90 E 22924

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Chew

(a) RESIDENCE NO. 1330 Hughes St St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Unk

(State or country)

PARENTS

10 NAME OF FATHER Wm Chew

11 BIRTHPLACE OF FATHER (city or town) Unk

(State or country)

12 MAIDEN NAME OF MOTHER Eliz Chew

13 BIRTHPLACE OF MOTHER (city or town) Unk

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed ____ 19 ____ ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1927, to June 6, 1927, that I last saw him alive on June 6, 1927, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Myocardial Failure

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) James M. Faulkner M. D.

6/7, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Ulrich's Lot Date of Burial June 8/27

20 UNDERTAKER Hamel Benton ADDRESS 916 Eutaw

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22925

CERTIFICATE OF DEATH.

E 22925

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 758 Druid Hill Ave St., (Ward) 7-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hall

(a) Residence No. 758 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, Divorced (write which) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Eliza Turpin

(Address) 507 Greenmillar Ave

Filed JUN 8 - 1927 192 H. [illegible] JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 5th 27

17- I HEREBY CERTIFY, That I attended deceased from June 2 1927 to June 5 1927

that I last saw him alive on June 5 1927

and that death occurred, on the date stated above, at 2.05 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(Duration) yrs. mos. 4 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul E. Wagner M. D.

6/6, 1927 (Address) 1611 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Zion Cem DATE OF BURIAL, June 8/1927

20-UNDERTAKER. Denis Easton ADDRESS 516 Cleveland

Spec.—1-12-23—M&T—500 Bks.

22926. HEALTH DEPARTMENT—CITY OF BALTIMORE 22926

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balto Gen. Hosp. (Street) 6-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Hill

(a) RESIDENCE (No.) Hebbville, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 22, 1908

7 AGE: Years 19 Months Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wilmington, N.C.

PARENTS

10 NAME OF FATHER: Joseph B. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilmington, N.C.

12 MAIDEN NAME OF MOTHER: Virginia Coltrane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): High Point N.C.

14 Informant: Joseph B. Hill (Address) Windsor Mill Rd nr Hebbville

15 Filed JUN 8 - 1927 Registrar C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2 1927 to June 6 1927

that I last saw him alive on June 6 1927

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis, with perforation Peritonitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/4/27

Was there an autopsy? No Operation

What test confirmed diagnosis?

(Signed) Louis F. Lavy, M. D.

1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: June 7 1927

20 UNDERTAKER: [illegible]

ADDRESS: 1003 W. Baltimore St

Spec.—1-12-23—M&T—500 Bks.

E 22927 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22927

CERTIFICATE OF DEATH. 124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 238 Colvin St. (WARD) 5-8

2-FULL NAME Elizabeth Coleman

(a) RESIDENCE NO. 238 Colvin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11 - 1850

7 AGE: Years 50 Months Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alex. Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Isabel Jones daughter

(Address) 238 Colvin st

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to June 5, 1927, that I last saw h alive on June 4, 1927, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs 2 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? h

Did an operation precede death? no Date of

Was there an autopsy? no physical

What test confirmed diagnosis?

(Signed) W. H. Young, M. D.

6/6, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: June 8 1927

20 UNDERTAKER: Samuel Hensley ADDRESS: 1300 Edmondson Ave

JUN 8 1927

E. HAMPSON JONES, M.D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22928

CERTIFICATE OF DEATH

11 E 22928

1-PLACE OF DEATH Md. Gen. Hosp. REGISTERED NO.

City of BALTIMORE: (No. 9-46 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elsie Morris

(a) RESIDENCE NO. 335 Forrest St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. If of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Morris

6 DATE OF BIRTH (month, day, and year): Aug 5 1900

7 AGE — Years: 26 Months: 10 Days: 2 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): (State or country) England

PARENTS

10 NAME OF FATHER: Stone

11 BIRTHPLACE OF FATHER (City or town): (State or country) England

12 MAIDEN NAME OF MOTHER: Ridges

13 BIRTHPLACE OF MOTHER (city or town): (State or country) England

14 Informant: Mrs Elsie Morris

(Address) 335 Forrest St

C. HAMILTON JONES, M. D.

15 Filed ____, 19 ____ Registrar

JUN 8 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-7 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6-5, 19 27, to 6-7, 19 27, that I last saw h[illegible] alive on 6-7-27, 19 , and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Uremia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-6-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial: June 10 1927

20 UNDERTAKER: [illegible] ADDRESS: 307 E Monument

very important. See instructions on back of certificates. Give statement of OCCUPATION 18

Spec. -7-17-26—A Co.—200 Bks.

E 22929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 22929

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1473 Woodall St. 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie J. Thompson

(a) RESIDENCE NO. 1473 Woodall St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Wm H. Thompson

6 DATE OF BIRTH (month, day, and year): June 24, 1869

7 AGE: Years 57 Months 10 Days 18 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Cheeching W. Va

(State or country)

PARENTS

10 NAME OF FATHER: Martin L. Duncan

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER: Elizabeth Brooks

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Wm H. Thompson

(Address) 1473 Woodall St

15 Filed JUN 8 1927 19 H. THOMPSON JONES, M. D. Registrar

Per K.A.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to June 6, 1927, that I last saw h 1 alive on June 6, 1927, and that death occurred, on the date stated above, at 11 2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pharyngitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. B. Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem Date of Burial June 9 1927

20 UNDERTAKER: Margaret S. Flynn ADDRESS 1417 Light St

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 22930 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22930

91-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 1675

CITY OF BALTIMORE: (No. Fayette & Carlton Sts. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Boyd

(a) RESIDENCE NO. 1322 W Lafayette St Ave WARD
(Usual place of abode)
Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widowed 17

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Boyd.

6 DATE OF BIRTH (month, day, and year): April 12, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): —
12 MAIDEN NAME OF MOTHER: Margaret —
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Beulah Hawkins 1322 Lafayette ave.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/5/27 19

I HEREBY CERTIFY, That I attended deceased from 5/17/27 19 to 6/5/27 19
that I last saw her alive on 6/5/27 19
and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Arteriosclerosis.
Acute Nephritis.
5/17/27 (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs.
(Signed) W. Wallace Walker, M. D.
19 (Address) Franklin Square Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery
DATE OF BURIAL: 6/9 1927
20 UNDERTAKER: Thomas E. Kelson
ADDRESS: 1303 Division

PRINT in very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22931

CERTIFICATE OF DEATH.

101-001

E 22931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Caroline ST. 79 WARD)

2-FULL NAME William Chavis

(a) RESIDENCE NO. 523 N. Caroline ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Taylor Elizabeth Chavis

6 DATE OF BIRTH (month, day and year) — — 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Wife E Chavis

(Address) 523 N Caroline st

15 Filed . 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2 . 1927 . to June 7 . 1927 . that I last saw h[illegible] alive on June 7 . 1927 . and that death occurred, on the date stated above, at 10:15 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) W. L. Henry , M. D.

. 19 (Address) 1502 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orange Va

DATE OF BURIAL June 9 1927

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument st

N.B. - 1927

Spec.—8-24-14—M. & T.—2000 Bks.

Harris

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22932
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31

E 22932
REGISTERED No. C

CITY OF BALTIMORE: (No. 1413 E Fayette ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Harris

(Residence in Baltimore: No. 1413 E Fayette St - St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH, ..., (Month) (Day) 1890 (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Thomas Jefferson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Harriet Jefferson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Jefferson

(Address) 1413 E. Fayette st

15-

Filed ....., 191.....

C. HAMPSON JONES, M. D.
Registrar.

6-1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1926, to June 6 1927, that I saw her alive on June 6 1927, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emil J. Allen M. D.

June 6, 1927 (Address) 108 Somerset

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Petersberg Va

DATE OF BURIAL, June 10, 1927

20-UNDERTAKER John W Henderson

ADDRESS 1302 E Monument

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22933

CERTIFICATE OF DEATH

E 22933

REGISTERED NO. 4[illegible]

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Stevens -

(a) RESIDENCE NO. 1011 Walnut St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years: 50 - Months: Days: IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer -

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va -

(State or country)

PARENTS

10 NAME OF FATHER Wm Stevens

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Alabama

12 MAIDEN NAME OF MOTHER Nancy Jackson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Alabama

14 Informant

(Address)

15 Filed 1927 Registrar

1430

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 6, 1927

that I last saw h[illegible] alive on June 6, 1927

and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach 3

(duration) 6 months

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Sign

(Signed) M Bluestein, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

G. HAMPSON JONES, M. D. UNIVERSITY OF MARYLAND. Commissioner of Health. JUN 8 - 1927

E very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 22934

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22934

CERTIFICATE OF DEATH.

REGISTERED NO. 16-2274

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1937 W. Lanvale St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Zarges

(a) RESIDENCE NO. 1937 W. Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced? (write the word): Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Adolph Zarges.

6 DATE OF BIRTH (month, day, and year): ~~Aug. 23, 1872~~ Aug 23 1862

7 AGE: Years 64 | Months 5 4 | Days 9 9 | If LESS than 1 day, hrs. or min. 16 16

June 14 1927 M. L. Ingram M.D.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Helena Peat School Philadelphia Pa

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: John Augustus Boers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Emma Benner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Mrs. M. McIver 1937 W. Lanvale St.

15 Filed 1927 Per 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1927, to June 8, 1927, that I last saw her alive on June 7, 1927, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? The usual ones

(Signed) M. L. Ingram, M. D.

6/8, 1927 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: June 10 1927

20 UNDERTAKER: Wm. J. Pickner Sons ADDRESS: Norrisville Pa

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22935

CERTIFICATE OF DEATH.

E 22935

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 111-0024

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 27-48 St. Ward)

2-FULL NAME Benj F. Marr

(a) RESIDENCE NO. 4901 Tioga Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Verdye B. Marr ~~Married~~

6 DATE OF BIRTH (month, day, and year) July 2-1879

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
~~48~~	47	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lon Das Elder Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin F Marr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Benner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Records

15 Filed ....., 19 ..... (G. HAMPSON JONES, M. D.) Registrar

1927 By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927, to June 7, 1927, that I last saw h~~im~~ alive on June 7, 1927, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows: ~~Gastric~~ Ulcer Perforated (~~Pulmonary~~) Embolism Duodenal

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) ..... yrs. ..... mos. 15 min

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of May 31, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. S. Hart M. D.

6/7, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial June 10 1927

20 UNDERTAKER Wm J Tickner Sons N. & Pa ADDRESS

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 22936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 22936

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1323 N Patterson Pk ave St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther S. M. Teufel

(a) RESIDENCE NO. 1323 N Patterson Pk ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 31 1927

7 AGE: Years Months Days 9 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: DOD

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Luther S M Teufel Sr

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Roseadine Baer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Luther S M. Teufel

(Address) 1323 N. Patterson Pk ave

15 Filed 1927 G. HAMPSON JONES, M. D. Registrar

Per AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1927, to June 8, 1927, that I last saw him alive on June 7, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Physical Examination

(Signed) Allen H. Saulsbury M. D.

June 8 1927. (Address) 2007 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: June 9 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: 1 Broadway

If the certificate is given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

(Hunter)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22937 (2031) — t 31 — E 22937

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital 7-4

REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Hunter

(a) RESIDENCE NO. Colfax W. Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House ? Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) W. Va

PARENTS

10 NAME OF FATHER Louis Broman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) W Va

12 MAIDEN NAME OF MOTHER Jane ? Kraus

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W Va ?

14 Informant Johns Hopkins Hospital

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D.

Per RCB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 8 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to June 8, 1927, that I last saw h[illegible] alive on June 8, 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

[illegible]

Acute tuberculosis of spleen

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral tuberculosis Sudden

Old chronic tbc lung (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W Va — Date of Burial 6/8/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22938

CERTIFICATE OF DEATH.

E 22938

187-06

24-33

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Durm's Ship Yard.

City of BALTIMORE: (No. Foot of Hanover St. St. 24 Ward)

2-FULL NAME Frank F. Larkins.

(a) RESIDENCE NO. 444 E. Cross St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXX Mary Larkins.

6 DATE OF BIRTH (month, day, and year) September 15, 1864.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship worker.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Durm's Ship Yard.

9 BIRTHPLACE (city or town):

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Do not know.

14 Informant Charles E. Larkins. (son)

(Address) 1812 Jackson St.

15 Filed 6-8-1927 C. HAMPSON JONES, M. D. Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries.
Caught and wrapped around a windlass
Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

(Signed) Otto Bernhardt M. D.
(Coroner)

6/8 · 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the state .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial June 9 1927

20 UNDERTAKER Margaret S. Flynn ADDRESS 14 W. Lexington St.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22939 129 E 22939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2113 W. Saratoga St. 20-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME McClellan J. Baltzell

(a) RESIDENCE NO. 2113 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. —ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meatan V. Baltzell

6 DATE OF BIRTH (month, day, and year) July 20 1862

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cutter and engraver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Thurmont

(State or country) md

PARENTS

10 NAME OF FATHER James W. Baltzell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Mary Ann Stouffer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Howard M. Baltzell

(Address) 2113 W. Saratoga st.

15 Filed ....., 19 HAMPSON (SUS M D)

Rec'd ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

17 I. Jan. 1927

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1926, to Jan 7, 1927, that I last saw h. m alive on Jan 7, 1927, and that death occurred, on the date stated above, at 1230 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) 1 yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? all-

(Signed) J. Thomas Tulson, M. D.

, 19 (Address) 1009 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Frederick Co Md Date of Burial June 10 1927

20 UNDERTAKER Chas. G. Black ADDRESS 142 N. North ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22940

CERTIFICATE OF DEATH.

129

E 22940

1-PLACE OF DEATH

City of BALTIMORE: (No. 644 N. Fulton ave. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Carroll Thomson.

(a) RESIDENCE NO. 644 N. Fulton Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: R. Sophia Thomson

6 DATE OF BIRTH (month, day, and year): Aug 17th 1866.

7 AGE: Years 60 | Months 9 | Days 20 21. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: U. S. Gov.

(b) General nature of industry, business, or establishment in which employed (or employer): Storekeeper.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER: James S. Thomson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York City N. Y.

12 MAIDEN NAME OF MOTHER: Maria L. Working

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant: Alfred H. Thomson

(Address) 326 E. 25th St.

15 Filed June 9, 1927 C. HAMPSON JONES, M. D. Registrar NRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June - 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept - 1, 1926, to June - 7 - 1927, that I last saw h[illegible] alive on June - 7 - 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Urinary & Blood

(Signed) Madison M. Stookey M. D.

6-7-27 (Address) 804 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial June 9 1927.

20 UNDERTAKER: Chas. G. Black ADDRESS 742 N. North

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22941

CERTIFICATE OF DEATH.

36-004

E 22941

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stein

(a) RESIDENCE NO. Esplanade Apt. 1 St. Ward C

(Usual place of abode)

Length of residence in city or town where death occurred lifetime yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of Nettie Stein

6 DATE OF BIRTH (month, day, and year) Jany 2 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Saml Stein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Hamburger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Mrs. Nettie Stein

(Address) Esplanade Apts

15 Filed ..7.. 1927 Per WRH C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7- 1927

17

I HEREBY CERTIFY, That I attended deceased from May-24 1927, to June 7 1927, that I last saw him alive on June 7th 1927, and that death occurred, on the date stated above, at 5 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse - Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of June 7th.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Abram J. Blechman, M. D.

6-7-, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Crematory Date of Burial 6/9/1927

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Mt. Royal Ave

Property of the State. Must be returned. Penalty for misuse of certificates. See instructions on back of certificate. OCCUPATION is very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22942

CERTIFICATE OF DEATH.

E 22942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 4-7 Ward)

2-FULL NAME Patrick Daughtery

(a) RESIDENCE NO. 421 ST. Paul St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: xxxxx

6 DATE OF BIRTH (month, day, and year): March 10/1857

7 AGE: Years 70 Months 1 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Balto., City

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Ireland

PARENTS

10 NAME OF FATHER: James Daughtery

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary ------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: James Daugherty (bro)

(Address): 1400 Linden Ave

15 Filed 19 C. HAMPSON Jones, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by automobile on North Point Road. Injury to spinal cord & fractured legs.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Watkins M. D. (Coroner)

6/8/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial 6/8 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave

(a) Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22943

E 22943

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH Balto City Hospital

City of BALTIMORE: (No. Balto Md St. 10-14

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Mullen

(a) RESIDENCE NO. 812 Willow St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James Mullen

6 DATE OF BIRTH (month, day, and year): 3/8/1886

7 AGE — Years: 41 — Months: 2 — Days: 29 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 37

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Balto City Hospls

(Address): Balto Md.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-7-27

17 I HEREBY CERTIFY, That I attended deceased from 6-3-, 1927, to 6-7-, 1927, that I last saw h[illegible] alive on 6-7-, 1927, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholic Delirium

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Alcoholic Psychosis Acute & Chronic Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Thos. J. Thompson M. D.

6/8, 1927 (Address) 1711 Eutaw Pl. 1736

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery Date of Burial: June 9 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave

very important. See instructions on back of certificates.

...ON is ...ABLE. ...ent of OCCUPA...

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22944

CERTIFICATE OF DEATH.

E 22944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2527 Eastern Ave St. 1-3 Ward)

2-FULL NAME John Muhlhan

(a) RESIDENCE NO. 2527 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Muhlhan

6 DATE OF BIRTH (month, day, and year) March 27, 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	2	10 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 28

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 16 years

(c) Name of employer United Railway

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Heidenblut

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Lillie Muhlhan

(Address) 2527 Eastern Ave

Filed. 1927 H. HAMPSON JONES, M. D.

Registrar

Per ARG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6 1927, to June 6, 1927, that I last saw h[im] alive on June 6, 1927, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. L. Ling, M. D.

6-8, 1927 (Address) 270 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
First Evangelical Cemetery	June 9 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1910 Fleet St.

Be sure answer to each question is complete, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22945

E 22945

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1330 Gilmor St., 15-22 Ward)

2-FULL NAME Mary Stanley

(a) RESIDENCE NO. 1330 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

3a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Robert Stanley

6 DATE OF BIRTH (month, day, and year) June 11, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Sarah Johnson

(Address) 1330 Gilmor St.

15 Filed June 7 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23 1927, to June 6, 1927, that I last saw h[illegible] alive on June 5, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey M. D.

6/6, 1927 (Address) 1928 E. Eng

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial June 9th 1927

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

8 - 1927

Spec.—1-12-23—M&T—500 Bks.

E 22946 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., H-7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Minahan

(a) RESIDENCE NO. Stevens Court W ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Minahan

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Harrows Pt

(c) Name of employer Steel Works

9 BIRTHPLACE (city or town) (State or country) Johnstown Penn.

PARENTS

10 NAME OF FATHER Wm. Minahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ray Minahan
(Address) 1116 E. 34 St. City

15 Filed 1827, 19 .....
G. HAMPSON JONES, M. D.
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 27, to June 6, 19 27,
that I last saw him alive on June 6, 19 27,
and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Curtis M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown, Pa

20 UNDERTAKER J. A. Moran

DATE OF BURIAL 6/9/ 19 27

ADDRESS 3-5 E. Baltimore

IMPORTANT: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22947 E 22947

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 S. Bond ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Anderson

(a) RESIDENCE NO. 718 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rose. Anderson

6 DATE OF BIRTH (month, day, and year) 3/5/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	47	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) German Poland

PARENTS

10 NAME OF FATHER Joseph. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) German Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rose Anderson (Wife)

(Address) 718 S. Bond St

15 June 8, 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8- 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926. to June 8- 1927.

that I last saw h[illegible] alive on June 6- 1927.

and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Intestines

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Carcinoma in

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Ries, M. D.

June 8, 1927 (Address) 24 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 6/10 1927

UNDERTAKER William Fiallowski ADDRESS 1618 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22948 — PLACE OF DEATH

E 22948 — REGISTERED NO.

City of BALTIMORE: (No. 1725 McCubbin St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Mitchell

(a) RESIDENCE NO. 1725 McCubbin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Mitchell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Francis Murray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Francis Mitchell

(Address) 1725 McCubbin St

15 Filed ..... 19 ..... J. HAMPDEN JONES, M. D. Registrar

NOV 9 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Epilepsy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Jones M. D.

(Coroner)

6/8/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial June 11, 27

20 UNDERTAKER Edward Bryon ADDRESS 1631 orleans st

If the physician in charge of the case, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22949

CERTIFICATE OF DEATH.

100-001 ✓

E 22949

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 910 Shutter St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Hill

(a) RESIDENCE NO. 910 Shutter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Wid Wer

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Bassell Hill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Harriett Bradley

(Address) 1823 Orleans St

15 Filed JUN 9 - 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jos. Kallen M. D.
(Coroner)

6/8/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Greenmount Cemetery June 9 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

IF DEATH IS FROM ANY FORM OF VIOLENCE, STATE WHETHER ACCIDENTAL, SUICIDAL OR HOMICIDAL. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Properly classified, so that it may be of property

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22950

CERTIFICATE OF DEATH.

101-001

E 22950

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1409 Myrtle Ave ST. 14 WARD) 20

2-FULL NAME Anthony Clash

(a) RESIDENCE NO. 1409 Myrtle Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 39 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 14-87

7 AGE: Years 39 Months 10 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John. Clash

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Lizzie Brent 820. Harlem Ave

15 Filed 19-1927 19 Registrar G. HAMPTON JONES, M. D.

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 7, 1927.

that I last saw h[illegible]live on June 6, 1927

and that death occurred, on the date stated above, at 12 P m

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1409 Myrtle Ave

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical history test

(Signed) John C Statham M. D.

1927 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Chapel — DATE OF BURIAL: 6-11 1927

20 UNDERTAKER: Wm H Grace & Son — ADDRESS: 1408 Madison

TION is very important See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 22951

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22951

129

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) 137 E West St. (St.) (Ward) 24 33

2-FULL NAME Frances F. Julier

(a) RESIDENCE NO. 137 E West St. Ward 24

(Usual place of abode)

Length of residence in city or town where death occurred 6 mos. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles F. Julier

6 DATE OF BIRTH (month, day, and year): January 23. 1864

7 AGE: 63 Years 4 Months 14 Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Werner C Rice

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Francis Hackman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Chas F. Julier

(Address) 137 E West St

JUN 9 - 1927

C. HAMPSON JONES, M.D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-7-27

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1927, to June 7, 1927,

that I last saw h alive on June 1, 1927.

And that death occurred, on the date stated above, at 2.48 A m.

The CAUSE OF DEATH* was as follows:

Chronic int. nephritis,

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin & phys.

(Signed) Wm Lee Stifler M. D.

6/8, 1927 (Address) 1319 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross AAC — Date of Burial 6-10 1927

20 UNDERTAKER: E + B Hasle — ADDRESS 1158 West St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 22952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22952

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 1

City of BALTIMORE: (No. Balto City Hospitals Ward) 1926

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Thompson -

(a) RESIDENCE NO. 1819 McHenry St. W Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Thompson

6 DATE OF BIRTH (month, day, and year): Dec 28 1870

7 AGE: Years 56 Months 5 Days 10 IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Va - (State or country)

PARENTS

10 NAME OF FATHER Gibson Arnette

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ruth Hamock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bessie Heard wife

(Address) 1819 McHenry St

15 Filed NOV 9 1927 19 C. HAMPTON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-8-27

17 I HEREBY CERTIFY, That I attended deceased from 6-2-, 19 27 to 6-8-, 19 27

that I last saw her alive on 6-8- 19 27

and that death occurred, on the date stated above, at 11 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 4 months ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Heywood M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — Date of Burial June 10 1927

20 UNDERTAKER: F. B. Heppicol — ADDRESS: 1850 W. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22953

CERTIFICATE OF DEATH.

E 22953

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 W. Mt Royal St. 11-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Keyes

(a) RESIDENCE NO. Wachulla Flor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ May Keys

6 DATE OF BIRTH (month, day, and year) Nov 11, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Warren

(State or country) Balto Co.

PARENTS

10 NAME OF FATHER Edward Keys.

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Charles Keys.

(Address) 125 W. Mt Royal Ave

15 Filed ..... 19 .....

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (duration) yrs. mos. 4 hrs

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 hr.

June 8 27 (Signed) G. E. Hayes M. D.

(Address) 143 W. Lanvale (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial June 11 1927

20 UNDERTAKER Ehrenworthson ADDRESS 3615 Elmland Ave

OF DEATH is plain words, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22954

CERTIFICATE OF DEATH.

E 22954
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. J Smith

(a) RESIDENCE NO. 1523 Lemon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Smith

6 DATE OF BIRTH (month, day, and year): Apr 9th 1873

7 AGE — Years: 55 Months: 1 Days: 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Martha Smith

(Address): 1528 Lemon st

15 Filed JUN 9 1927 19

HAMPSON JONES, M. D.

Per R.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull - Cerebral Hemorrhage

(Duration) 7 hours

CONTRIBUTORY (Secondary): Struck by Street Car

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

June 9 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: June 12th 1927

20 UNDERTAKER: A. Jones ADDRESS: 111 S Gay St

Filed. 1927

Cor.—12-9-25—A Co.—200 Bks. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22955

CERTIFICATE OF DEATH.

E 22955

1-PLACE OF DEATH

City of BALTIMORE: (No. Stmr. Juneta Pier 8 Pratt St. St. 46 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold McCoy.(C)

(a) RESIDENCE NO. Jacksonville Florida. St. Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman.

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant & Miners S. S. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Jacksonville, Fla.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Jacksonville, Fla.

12 MAIDEN NAME OF MOTHER Lettie Byrd.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Jacksonville Fla.

14 Informant T. H. Swank.

(Address)

15 Filed JUN 9 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Pistol shot wound of the chest.
Homicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clark Bernhardt M. D.
(Coroner)

6/9, 1927 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jacksonville Florida Date of Burial Jun 7 1927

20 UNDERTAKER William Cooks ADDRESS 52 E Balto

IF DEATH IS from any form of violence, state whether accidental, suicidal or homicidal. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Use black ink and write in plain terms, so that it may be properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22956 5/J E 22956

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3043 Brighton St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Cornelia Sweany

(a) RESIDENCE NO. 3043 Brighton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1859

7 AGE	Years	Months	Days 15	IF LESS than 1 day hrs. or min..
	67	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Sweany

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah C. Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Miss Grace Sweany

(Address) 3043 Brighton St.

Filed JUN 9 - 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to June 8, 1927, that I last saw her alive on June 7th, 1927, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary.

(Signed) Herbert F. Kleeman M. D.

. 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — Date of Burial June 11 1927.

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

22957

HEALTH DEPARTMENT—CITY OF BALTIMORE

J 74-001

E 22957

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) R 138 Oak St. 12-51 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Melvina Rhea.

(a) RESIDENCE NO. 2138 Oak St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Thomas E. Rhea.

6 DATE OF BIRTH (month, day, and year): Oct 11th 1851

7 AGE: 75 Years 76 Months 7 Days 27

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Dorchester Co

(State or country) Md.

PARENTS

10 NAME OF FATHER: William Thomas.

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER: Susan Wright

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: William H. Thomas Brother

(Address) 2138 Oak St

15 Filed JUN 9 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to June 8th, 1927, that I last saw her alive on June 7th, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Sordy M. D.

1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: June 10 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22958

CERTIFICATE OF DEATH

31 E 22958

1-PLACE OF DEATH REGISTERED NO. 20-28

City of BALTIMORE: (No. 2006 Wilhelm St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Kaurly

(a) RESIDENCE NO. 2006 Wilhelm St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Elizabeth Kaurly

6 DATE OF BIRTH (month, day, and year): Sept 23 1881

7 AGE Years: 45 Months: 8 Days: 16 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Draw worker

(b) General nature of industry, business, or establishment in which employed (or employer): 079

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: John Kaurly

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Katherine Geiger

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs Elizabeth Kaurly

(Address) 2006 Wilhelm

15 Filed JUN 9 - 1927 C. HAMPTON JONES, M. D. Registrar

Per RAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 8

17 I HEREBY CERTIFY, That I attended deceased from June 7 1927 to June 7 1927

that I last saw h.. alive on June 7 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo W Waldeman M. D.

(Address) 1900 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial: June 10 1927

20 UNDERTAKER: John O Mitchell & Sons ADDRESS: 1900 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

22959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11/1 E 22959

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hosp St. 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jessie Roxborough

(a) RESIDENCE NO. 1715 Poplar Grove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Carlton L. Roxborough.

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	36	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Jacob Norris

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER M. Warfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co. Md.

14 Informant Husband.

(Address)

15 Filed JUN 9 1927 19 G. HAMPSON JONES, M. D.

Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/27, 1927, to 6/7, 1927, that I last saw h[illegible] alive on 6/7/27, 19, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Ruptured Right cystic ovary

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. 10 min ds.

18 Where was disease contracted Unknown

if not at place of death?

Did an operation precede death? Yes Date of 5/30/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) Geo. A. Tyndall, M. D.

, 19 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemy. Date of Burial June 9 1927

20 UNDERTAKER John C. Mitchell & Sons ADDRESS 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

E 22960

1-PLACE OF DEATH E 22960

REGISTERED NO.

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Lanehan

(a) RESIDENCE NO. Preston + Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Lanehan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catharine London

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed JUN 9 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 7th

17 I HEREBY CERTIFY, That I attended deceased from My Record, 19..., 19..., that I last saw h.. alive on ..., 19..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

8, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial June 10 1927

20 UNDERTAKER Bela Wiedefeld ADDRESS 9th & Greenmount Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-28—M&T—500 Bks.

E 22961

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22961

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 St Paul ST. 4-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kieran Weir

(a) RESIDENCE NO. 312 St Paul ST., WARD 4th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David G. Weir

6 DATE OF BIRTH (month, day, and year): Mar 25-1839

7 AGE: Years 88 Months 2 Days 14 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iceland

PARENTS

10 NAME OF FATHER: Matthew Kieran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iceland

14 Informant: Mrs Margaret Weir

(Address): 312 St Paul St

15 Filed , 19 G. HAMPSON JONES, M. D. Registrar

By RKK

JN 9 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 - 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10th, 1910, to June 8th - 1927,

that I last saw her alive on June 8 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

To my knowledge

(duration) 17 yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Senile Debility due to old age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances A. Carpenter, M. D.

6-5, 1927 (Address) 2101 Madison Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL June 11 27

UNDERTAKER: Chas. F. Kraus & Son ADDRESS 1810 W. Royal Ave

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22962

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3950 Edgehill Rd St. 12-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Butler

(a) RESIDENCE NO. 2733 Fox St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip Butler

6 DATE OF BIRTH (month, day, and year): June 5 1891

7 AGE — Years: 36 — Months: — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Lucor Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Boston Mass.

12 MAIDEN NAME OF MOTHER: Sarah Lee

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Sarah Williams

(Address) 2733 Fox St.

15 Filed JUN 9 - 1927 HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John M. Morrissey M. D. (Coroner)

6/8, 1927 (Address) 1622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va Date of Burial: June 8 1927

20 UNDERTAKER: Wm. R. C. Elliott ADDRESS 1025 Eutaw Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22963

CERTIFICATE OF DEATH.

E 22963

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2916 Iona Terrace Ward 23 8-44)

2-FULL NAME Charles Bohnlofink

(a) RESIDENCE NO. 2916 Iona T St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. B.

6 DATE OF BIRTH (month, day, and year) Aug 21 57

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Bohnlofink

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Emma B. Bohnlofink

(Address) 2916 Iona Ter.

C. HAMPTON JONES, M. D.

15 Filed 19

Per Registrar

NOV - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 - 27 19

17 I HEREBY CERTIFY, That I attended deceased from May - 17 1927, to June 7 - 1927

that I last saw h— alive on June 6 1927

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis —

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 6 ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [illegible], M. D.

, 19 (Address) 1254 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial June 10 1927

20 UNDERTAKER W M Rowton ADDRESS 223 N Howard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22964

E 22964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Mount ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Evans

(a) RESIDENCE NO. 501 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of John Evans

6 DATE OF BIRTH (month, day, and year) 11-25-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55-	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Anne Arundle Co Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundle Co Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. known

14 Informant Mary E. Taylor (Address) 501 N. Mount St.

15 Filed JUN 3 - 1927 C. HAMPSON JONES, M. D. Registrar By K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27- , 1927 , to June 6- , 1927 , that I last saw h- alive on June 6- , 1927 , and that death occurred, on the date stated above, at 10-20P, m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) - yrs. - mos 11 ds.

CONTRIBUTORY (Secondary) Md. definitely known

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Thos. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem

DATE OF BURIAL 6/9/ 19 27

20 UNDERTAKER Howard S. Newcomer

ADDRESS 502 Biddle

INSTRUCTIONS.—Write plainly in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22965

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 N. Bouldin St. St. 76-2 Ward)

2-FULL NAME Anna M. Otto

(a) RESIDENCE NO. 616 N. Bouldin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 12th 1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	13	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) City

PARENTS

10 NAME OF FATHER Henry T. Otto

11 BIRTHPLACE OF FATHER (city or town)

(State or country) D.C.

12 MAIDEN NAME OF MOTHER Catherine Geier

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Catherine Otto

(Address) 616 N. Bouldin St.

15 Filed JUN 9 - 1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hem. Fractured skull at base. Fell in dining room. Probably slipped

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Hollman M. D.
(Coroner)

6/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz plem 6/10/27 Date of Burial

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 7-17-26—A Co.—200 Bks.

E 22966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124

E 22966

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 219 N. Pine St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Edwards Hargrove

(a) RESIDENCE NO. 219 N. Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (Write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 29-1875

7 AGE: Years 52 Months 1 Days 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Daniel Edwards

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Estella Hargrove

(Address) 219 N Pine St.

Filed JUNE - 1927 19 HAMPTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 5 - 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1927, to June 4th, 1927.

that I last saw her alive on June 4, 1927.

and that death occurred, on the date stated above, at 6.05 a m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. Kaiser, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial June 9 1927

20 UNDERTAKER: Samuel Thursby ADDRESS 1228 E

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

Telp.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22967

54

CERTIFICATE OF DEATH

E 22967

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [illegible] St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Telp

(a) RESIDENCE NO. 29 S. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthew Telp

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: Years 30 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thurman Thompson.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Horsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed JUN 9 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R. R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2 1927 to June 5 1927

that I last saw h[illegible] alive on June 4 1927

and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Female Laboratory

(Signed) C D Hooper Lamb M. D.

June 5 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cem Date of Burial: June 9. 1927

20 UNDERTAKER: Wendell J. Hoppel ADDRESS: 300 E Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

E 22968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 22968

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 804 Venable Ave St.; 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Milton Zacharias

(Residence in Baltimore: No. 804 Venable Ave. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 23, 1853 (Month) (Day) (Year)

7-AGE, 73 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or 16 ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): The Hub

9-BIRTHPLACE, (State or Country), Westminster Md.

PARENTS.

10-NAME OF FATHER, Jacob Zacharias

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Orndorf

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Laura D. Zacharias

(Address) 804 Venable Ave.

15- Filed JUN 9 1927 191 C. HAMPSON JONES, M. D. Registrar.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1927, to June 8 1927, that I saw h— alive on June 8 1927, and that death occurred, on the date stated above, at 7 45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with mitral regurgitation of heart (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) yrs. mos. 5 ds.

(Signed) H. J. Stuckler Jr. M. D.

June 9, 1927 (Address) 632 Gorsuch Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, June 11, 1927

20-UNDERTAKER Wm. Fletcher Ross ADDRESS North & Pa

Important. See instructions on back of certificate. OCCUPATION is very

Cor.—12-9-25—A Co.—200 Bks.

E 22969

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 1 Ward)

REGISTERED NO. 188-093

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Ey.

(a) RESIDENCE NO. 800 S Linwood St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Josephine Ey.

6 DATE OF BIRTH (month, day, and year) March 2nd 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman at

(b) General nature of industry, business, or establishment in which employed (or employer) Health Dept.

(c) Name of employer Balto. Md.

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Ey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Charles T. Ey.

(Address) 114 Cutty Hill Ave Cubster

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUN 9 - 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Multiple Fractures

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

June 9 1927 (Signed) H C Hartz M. D. (Coroner)

(Address) 1430 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial June 10 1927

UNDERTAKER D. Lilly - Zeller ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 22970

REGISTERED NO.

E 22970

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 S. Robinson St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam J. Baier

(a) RESIDENCE NO. 812 S. Robinson St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	25	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Mahon Bud Co.

(c) Name of employer Monumental Court Co.

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Baier

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Müller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Kunigunda Baier (Mother)

(Address) 812 S. Robinson St.

Filed JUNE 9 - 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R. R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to June 7, 1927

that I last saw h im alive on June 6, 1927

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lymphat. Tb.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum - X ray.

(Signed) N. J. Dendos, M. D.

, 19 (Address) 3035 Dorman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — Date of Burial June 11 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 22971

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22971

CERTIFICATE OF DEATH

REGISTERED NO. 22948

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Graham

(a) RESIDENCE NO. Ready Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Graham

6 DATE OF BIRTH (month, day, and year) May 7, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER John Arnold

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed 9 - 1927 16 G. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to June 8, 1927, that I last saw her alive on June 8, 1927, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

Arteriosclerosis with hypostasis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Date of Burial June 11 1927

20 UNDERTAKER William Calder & Nadler ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22972

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 4-25 Ward)

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Worth

(a) RESIDENCE NO. 662 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baptist Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

1438

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Cain M. D.

(Coroner)

5/31/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 192

20 UNDERTAKER ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22973

66 E 22973

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 S Potomac St. 1-1 Ward)

2-FULL NAME Simon Sedlair

(a) RESIDENCE NO. 911 S Potomac St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Ne	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia Poland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ....., 19 .....

By _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) G Lawson

(duration) yrs. mos. ds.

(Signed) G C Yates M. D.
(Coroner)

, 19 (Address) 113 E 13 Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1927 C. HAMPSON JONES, M. D.

1434

UNIVERSITY OF MARYLAND 9 - 1927

Department of Health

THIS MORGUE

Spec.—12-9-25—A Co.—200 Bks.

E 22974 (483)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+84 E 22974

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 1-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Colborn

(a) RESIDENCE NO. Alma, W. Va. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 5 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Parker G. Colborn

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va

(State or country)

PARENTS

10 NAME OF FATHER Isaac DeFong

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Sara Haught

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 ~~JOHNS HOPKINS HOSPITAL~~

Informant

(Address) ~~C. HAMPSON JONES, M. D.~~

15 Filed ____, 19 ____ by ____ Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ~~year~~) June 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1927, to June 8th, 1927, that I last saw h.. alive on June 8th, 1927, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, dural endothelioma, (benign)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of June 8th 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) George G. Finney, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sisterville W Va — Date of Burial 6/9/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22975 — CERTIFICATE OF DEATH. — E 22975

1-PLACE OF DEATH Franklin Square Hospital — REGISTERED NO. 24-34

CITY OF BALTIMORE: (No. Fayette E. Gilmore St.) — WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henry Becker

(a) RESIDENCE NO. 1509 Marshall St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Becker

6 DATE OF BIRTH (month, day, and year): June 2, 1859

7 AGE — Years: 68 — Months: 0 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooperage Business

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: August Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Peterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Mary E. Becker 1509 Marshall St.

15 Filed 6-19-1927 G. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from 6/4/27, 19, to 6/7/27, 19, that I last saw him alive on 6/7/27, 19, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 hrs ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) 6/7/27 Immediate ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs.

(Signed) Harry Weibel M. D.

(Address) 1116 Walker Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 10 1927.

20 UNDERTAKER: Mr & Mrs. John H. Teufel & Son — ADDRESS: 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

9 - 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22976

CERTIFICATE OF DEATH

E 22976

REGISTERED NO. 13-52

1-PLACE OF DEATH

City of BALTIMORE: (No. 816 West 33 rd St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy A. Tracey.

(a) RESIDENCE NO. 816 West 33 St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white.	widow.

5a If married, widowed, or divorced ~~HUSBAND~~ WIFE of Thomas S. Tracey.

6 DATE OF BIRTH (month, day, and year) Jan/4.th/1837.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	90.	5.	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife .

(b) General nature of industry, business, or establishment in which employed (or employer) Retired.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Tracey.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Clara B. Grimes.

(Address) 816. West. 33 St.

15 Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8.th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to June 7, 1927, that I last saw her alive on June 7, 1927, and that death occurred, on the date stated above, at 2. A m

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) C. J. Dane, M. D.

6/8/27. (Address) 800. W. 33 rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hereford Baptist church cem. Date of Burial 6/11/ 1927.

20 UNDERTAKER J. Walter Davis. ADDRESS 3807 Raine St.

NOW should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 22977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 22977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N. Broadway WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baker

(a) RESIDENCE No. 1304 N. Broadway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
				7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Ralph Baker

11 BIRTHPLACE OF FATHER (city or town) Edenberg (State or country) Va

12 MAIDEN NAME OF MOTHER Lillian D. Boos

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown (State or country) Md.

14 Informant Lillian D. Boos (Address) 1304 N. Broadway

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 8, 1927, that I last saw h[illegible] alive on June 8, 1927 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 Mths Gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stanley L. Reichelderfer, M. D.

6-9, 1927 (Address) 1650 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

DIRECTION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

6-9 1927 Reg. 1436

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22978

E 22978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

2-FULL NAME Mrs Bella Gredberg.

(a) RESIDENCE NO. 228 R St. N.E. Wash. D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jules Goldberg

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE: Years 26 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Russia

PARENTS

10 NAME OF FATHER: Jules Kaplan

11 BIRTHPLACE OF FATHER (city or town): (State or country) Russia

12 MAIDEN NAME OF MOTHER: Sophia Kaplan

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Russia

14 Informant: Jules Goldberg (Address) 228 R St N.E. Wash D.C.

15 Filed JUN 10 1927 H. M. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/10/ 1927

17

I HEREBY CERTIFY, That I attended deceased from 5/25/ 1927, to 6/10/ 1927, that I last saw her alive on 6/10/ 1927, and that death occurred, on the date stated above, at 2.10a m.

The CAUSE OF DEATH* was as follows:

Lung abscess following tonsilectomy

(duration) yrs. mos. 72 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John A. Arkin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. Date of Burial: 6/10 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1139 F N.W.

IMPORTANT.—In answering each question, ANSWER SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22979

CERTIFICATE OF DEATH.

1355

REGISTERED NO. E 22979

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 6-10 Ward)

2-FULL NAME Isaac Grossman

(a) RESIDENCE NO. 2226 E Fairmount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida Grossman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Leurs

(Address) 1439 E Balt St

15 Filed ..... 19 ..... Registrar

JUN 10 1927 E. HAMPSTEAD, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to June 9, 1927, that I last saw him alive on June 9, 1927, and that death occurred, on the date stated above, at 4 45 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate (Benign)

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac failure.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of June 7-1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. Hyman, M. D.

6/9, 1927 (Address) Sth.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

North Point & Emerson Hill 6/10 1927

20 UNDERTAKER ADDRESS

Jack Leurs 1439 E Balt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 22980

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22980

31V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S Marine Hospital ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Oliver

(a) RESIDENCE No. 2205 Hamler Street ST. Baltimore WARD Md

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 21-1906

7 AGE: Years 21 Months 2 Days 16 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Schooner M.E. Roberts

9 BIRTHPLACE (city or town) (State or country): Danville Virginia

PARENTS

10 NAME OF FATHER: John Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Nora Ralsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant: Hospital Records (Address)

15 Filed JUN 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 20 1927 to June 7 1927 that I last saw h[illegible] alive on June 7 1927 and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Larynx

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical findings & Laboratory tests

(Signed) John Denton M. D.

6-7-1927 (Address) A.A. Surgeon, U.S.P.H.S. U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery

DATE OF BURIAL: June 10, 1927

20 UNDERTAKER: E. Leroy Stiffler

ADDRESS: 125 E. North Ave

CAUSE OF DEATH may be entered by physician only if properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 10 1927

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-002

10 E 22981

E 22981

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Bentalou St. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Levin Becker

(Residence in Baltimore: No. 1407 Bentalou St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 20, 1921
(Month) (Day) (Year)

7-AGE, 6 yrs. mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edward Becker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Helen Hook

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Becker

(Address) 1407 Bentalou St

15- Filed JUN 10 1927, 191 G. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 9, 1927, that I saw h m alive on June 9, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Love M. D.

June 9, 1927 (Address) 826 Wood a

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, June 10, 1927

20-UNDERTAKER Josiah Syfer — ADDRESS 1600 N. York

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 22982

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22982

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH University Hospital 14-27 Registered No.....

City of BALTIMORE: (No. Lombard & Greene St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Laster

(a) Residence No. 316 N. Bruce St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-28-27

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, 3 hrs. or.... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Md.

PARENTS.

10-NAME OF FATHER, John Laster

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Va

12-MAIDEN NAME OF MOTHER, Sophie Matthews

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Md

14- (Informant).....

(Address).....

15- JUN 10 1927 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-29-27

17- I HEREBY CERTIFY, That I attended deceased from 5-28 1927 to 5-29 1927

that I last saw h[illegible] alive on 5-29 1927

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Maternal Nephritis

Prematurity

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Congenital

Atelectasis (Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eva F. Dodge M. D.

19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. University Hospital

DATE OF BURIAL ..... 19....

20-UNDERTAKER.

ADDRESS

In plain terms, so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22983

CERTIFICATE OF DEATH

3 1 ✓

E 22983

1-PLACE OF DEATH 3503 Norwood ave

REGISTERED NO.

City of BALTIMORE: (No. 3503 Norwood ave St. 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Cecelia Hammack

(a) RESIDENCE NO. 3503 Norwood ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm. McK. Hammack

6 DATE OF BIRTH (month, day, and year) Dec. 7–1856

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	70	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Maryland – Prince Georges Co.

PARENTS

10 NAME OF FATHER Thomas Markwood

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Martha C. Markwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Prince Georges Co.

14 Informant Mrs A. H. Brock

(Address) Fla.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

Per K.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 9–1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1926, to June 9, 1927, that I last saw h~~e~~r alive on June 9, 1927, and that death occurred, on the date stated above, at 1145a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Tibbett, M. D.

19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — Date of Burial June 11 1927

20 UNDERTAKER Geo. W. Little — ADDRESS 2700 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNI ... 1927

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22984

CERTIFICATE OF DEATH.

E 22984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanatorium 10-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Crump, alias Mary Grace

(a) RESIDENCE. NO. 513 N. Pulaski ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 27 879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Newman Son

9 BIRTHPLACE (city or town) (State or country) Chesterfield Co Va

PARENTS

10 NAME OF FATHER Thadeus B Crump

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chesterfield Co Va

12 MAIDEN NAME OF MOTHER Fannie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chesterfield Co Va

14 Informant Thadeus B Crump
(Address) 513 N Pulaski St

15 Filed JUN 10 1927 19 C. HAMPSON JONES, M. D. Registrar

By R.N.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1926 to June 9, 1927, that I last saw h.. alive on June 9, 1927, and that death occurred, on the date stated above, at 8.15 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Poison

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer Epithelioma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Cheeke M. D.

6-10 1927 (Address) 2129 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 13-27 19

20 UNDERTAKER Edward A Fink ADDRESS 734 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22985 ✓

E 22985

CERTIFICATE OF DEATH

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 2531 Christian St. Ward 11-64)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Kanely

(a) RESIDENCE NO. 2531 Christian St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Geiger

6 DATE OF BIRTH (month, day, and year): Oct 13. 1850

7 AGE — Years: 76 Months: 7 Days: 26, IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Kanely

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Keziah Galloway

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Charles Kanely

(Address) 3242 O'Donnell St

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to June 9, 1927, that I last saw him alive on June 7—, 1927 and that death occurred, on the date stated above, at 4:10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) A. Hellen Hemmeter, M. D.

6/9, 1927 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial June 11 1927

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS 1900 Eutaw Place

JUL 10 1927 C. HAMPSON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22986

CERTIFICATE OF DEATH.

65-001

REGISTERED NO. E 22986

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 N. Fulton av. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clara Virg. Griffin

(a) RESIDENCE NO. 1416 N. Fulton av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Harry N. Griffin

6 DATE OF BIRTH (month, day, and year): Aug. 6th 1854

7 AGE: Years 72 | Months 10 | Days 3 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Jos. Dorsey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Carr. Co. Md.

12 MAIDEN NAME OF MOTHER: Delilah Beatty

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Mrs. Nettie Rea Griffin

(Address) 1416 N. Fulton Av

Filed JUN 10 1927 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9th 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec'l, 1926, to June 9th, 1927, that I last saw h[illegible] alive on June 8th, 1927, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Val. Heart Dis. following old Injury, dropsy & gangrene of Legs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis & Paralysis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Verbal

(Signed) [signature], M. D.

6/9, 1927 (Address) 1605 N. Howard av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Date of Burial: June 11 1927

UNDERTAKER: John C. Mitchell & Sons ADDRESS: 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22987

CERTIFICATE OF DEATH.

1700

E 22987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 E. Eager St St., 9-18 Ward)

2-FULL NAME William Lindt

(a) RESIDENCE NO. 1530 Holbrook St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Katherine Lindt

6 DATE OF BIRTH (month, day, and year) Oct 10-1877

7 AGE	Years	Months	Days 28	IF LESS than 1 day.....hrs. or.....min.
	49	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Receiving Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Lindt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Dora Baschart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant Katherine Lindt

(Address) 1530 Holbrook St

15 Filed JUN 10 1927 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage
Pistol Shot wound. Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

6/9/27 (Address) 508 e. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial June 10 1927

20 UNDERTAKER William Cook ADDRESS 502 E Lexington St

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 22988

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22988

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2029 E Oliver St. 8-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Krepp

(a) RESIDENCE NO. 2629 E Oliver St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Late Elizabeth Krepp

6 DATE OF BIRTH (month, day, and year) April 21 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Michael Brickner

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Knecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Gettmeyer

(Address) 2029 E Oliver St

15 Filed JUN 10 1927 16 C. HAMPSON JONES, M. D. Registrar

Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1927, to June 8, 1927, that I last saw h in alive on June 8, 1927, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmit, M. D.

June 9 1927 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	June 11 1927
20 UNDERTAKER Henry Horck Son	ADDRESS 1301 E Eager St

N 107927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-8-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 22989

CERTIFICATE OF DEATH.

E 22989

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence D. Jenkins

(a) RESIDENCE NO. 1619 Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) May 18/27

7 AGE	Years	Months	Days 20	IF LESS than 1 day ....hrs. or ....min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Luther Jenkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Kiah

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Marie Jenkins

(Address) 1619 Orleans St.

Filed JUN 10 1927 C. HAMPSON JONES, Per RKK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Bacon, M. D.

(Coroner)

6/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery Date of Burial June 10 1927

20 UNDERTAKER Edward Bryan ADDRESS 631 Orleans st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

203360

E 22990

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 25-75

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Hagner

(a) RESIDENCE NO. 202 N. 1st St. St. ____ Ward Brooklyn, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hagner

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	about 78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Carter

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Leppihan

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) ____

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed JUN 10 1927 C. HAMILTON JONES, M. D. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 8, 1927

I HEREBY CERTIFY, That I attended deceased from May 18, 1927, to June 8, 1927, that I last saw h[illegible] alive on June 8, 1927, and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction, partial

Carcinoma - general

(Duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Central Stenosis, Intestinal Adhesion (duration) 15 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at operation in 1912

Did an operation precede death? Yes Date of May 28, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Henry G. Feldegan, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial 6-11 1927

20 UNDERTAKER Ehrlich Harle ADDRESS 115 E Mount St

Section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.–5200 Bks.

E 22991

HEALTH DEPARTMENT—CITY OF BALTIMORE

124

E 22991

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph's Hospital St. 5-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie Nichols

(a) RESIDENCE NO. 1746 S. Kanawha St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 27, 1872

7 AGE — Years: 55 Months: 0 Days: 11 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectionary

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer: Self

9 BIRTHPLACE (city or town)

(State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Nichols

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Fleming

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Ireland

14 Informant: Frank Nichols

(Address): 3905 Liberty Heights

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-1- 1927, to 6-8- 1927, that I last saw h[illegible] alive on 6-8-27 1927, and that death occurred, on the date stated above, at 12-45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-2-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) Clement R. Howard M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery Kingsville — Date of Burial: June 11 1927

20 UNDERTAKER: William Cook — ADDRESS: 5021 York Rd.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G. THOMPSON JONES, M.

E 22992 200 Bks.

Dr Krumreis 722 N Kenwood ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22992

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 26-39 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No.) 3910 Philadelphia Ave (Ward)

2-FULL NAME Clement C Priller

(a) RESIDENCE NO. 3910 Philadelphia Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Priller

6 DATE OF BIRTH (month, day, and year): May 26 1873

7 AGE: Years 54 Months 0 Days 13 If LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: C. P. Telephone Co

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Frederick F Priller

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary E Kellner

13 BIRTHPLACE OF MOTHER (City or town) Baltimore Md

(State or country)

14 Informant: Kate Priller

(Address) 3910 Philadelphia Ave

15 Filed JUN 9 1927 19 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 9, 1927, that I last saw h[im] alive on June 8, 1927, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (6 mos)

Laryngeal Tuberculosis (2 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum - X-Ray.

(Signed) Louis F Krumreis, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Date of Burial June 11 1927

20 UNDERTAKER Williamson & Edson ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.—200 Bks.

E 22993 HEALTH DEPARTMENT—CITY OF BALTIMORE

86 V-661

E 22993

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

City of BALTIMORE: (No. 9-47 Street Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Harris

(a) RESIDENCE NO. St Elizabeth Orphanage Street Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. B. Harris

6 DATE OF BIRTH (month, day, and year) May 3 1879

7 AGE Years 48 Months 1 Days 6

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer St Elizabeth Orphanage

9 BIRTHPLACE (city or town)

(State or country) Pa

PARENTS

10 NAME OF FATHER Charles A Ford

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie N. Morris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Del.

14 Informant Charles A Ford

(Address) 113 Pennsylvania Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1927 to June 9, 1927

that I last saw her alive on June 7, 1927

and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows: Otitis Media

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Elliott M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial June 11 1927

20 UNDERTAKER J. M. Cook ADDRESS 517 E Pratt St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22994

CERTIFICATE OF DEATH.

E 22994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 336 (ST.) Rossiter Ave (WARD) 27-48

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Maynard Hilbert

(a) RESIDENCE NO. 336 ST., Rossiter Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8th 1927

7 AGE: Years | Months | Days 1 | If LESS than 1 day 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Walter E. Hilbert

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Wyant

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Walter E. Hilbert (Address) 336 Rossiter Ave

15 JUN 10 1927 C. CAMPBELL JOHNSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8th 1927 to June 9th 1927 that I last saw him alive on June 9th 1927 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

(Birth Prematurity)

(duration) yrs. 1 mos. day ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 12 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) P. E. Fuller M. D.

(Address) 5 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery DATE OF BURIAL June 10 1927

20 UNDERTAKER: Thenowetholson ADDRESS 3615 Clifton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 22995 (PLACE OF DEATH)

E 22995 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (1) No. 607 Brook Ave Ward 27 St. 27 42

2-FULL NAME Rosie A Bussey

(a) RESIDENCE No. 607 Brook St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 13, 1882

7 AGE: Years 44 Months 6 Days 25 If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co

PARENTS

10 NAME OF FATHER: Thos A Bussey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co

12 MAIDEN NAME OF MOTHER: Rebecca Stonebraker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co.

14 Informant (Address): Mrs Annie Smith 20 W Lafayette St

15 [illegible] 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1927

17

I HEREBY CERTIFY, That I attended deceased from May 7 1927, to June 8 1927, that I last saw h[illegible] alive on June 8 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Phthisis

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D Joyce M. D.

19 (Address) Conowingo Cecil Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Ignatius Cemetery Harford Co

DATE OF BURIAL: June 10 1927

20 UNDERTAKER: Harry H. Witzke

ADDRESS: 1534 W. Lombard

JUN 10 1927

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

Mrowczynski

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 22996

CERTIFICATE OF DEATH.

REGISTERED NO. E 22996

1-PLACE OF DEATH

City of BALTIMORE: (No. 311 S Chester St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva. Mrowczynski

(a) RESIDENCE NO. 311 S. Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 10 27

7 AGE: Years — Months — Days — IF LESS than 1 day ... hrs. 2 or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Albert Mrowczynski

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Helen Tidlowski

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Albert Mrowczynski

(Address): 311 S Chester St

Filed JUN 10 1927 19 C. HARRY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 10, 1927, that I last saw h[illegible] alive on June 10, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rosnick, M. D.

(Address) 501 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Greenmount Cemetery June 10 1927

UNDERTAKER: George A. Weber ADDRESS: 2205 Bank

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 22997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21-29 188-003

E 22997

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Julian.

(a) RESIDENCE NO. 1059 Ward St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): June 11, 1867

7 AGE	Years	Months	Days 26	IF LESS than 1 day.....hrs. or.....min.
	59	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Italy.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Do not know.

14 Informant: Thomas A. Julian. (son)

(Address): Washington Blvd.

15 Filed JUN 10 1927, 19

Registrar: C. HAMPSON JONES, M. D.

Per RK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Struck and knocked down by an automobile while crossing the street, Accidental death. (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

(Signed) Chas. R. Reinhardt M. D. (Coroner)

6/10 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? Hanover st nr. Wells. June 7, 1927.

Former or usual residence:

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: 6/11 1927

20 UNDERTAKER: L. P. Fusselbaugh — ADDRESS: 620 St Paul

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22998

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

170

E 22998

REGISTERED NO.

City of BALTIMORE: (No. 1730 Alice Anne St. 2-4 Ward)

2-FULL NAME Wm. A Kunnecke.

(a) RESIDENCE NO. 1730 Alice Anne St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Josephine Kunnecke

6 DATE OF BIRTH (month, day, and year): Oct 18 1865

7 AGE: Years 61 Months 7 Days 18. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler-do

(b) General nature of industry, business, or establishment in which employed (or employer): Maker do

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Kunnecke

11 BIRTHPLACE OF FATHER (city or town).....

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Henretti Knockstadt

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country): Germany

14 Informant: Wm. Kunnecke

(Address): 1935 E Fairmount Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D.

Per ..... Registrar

UN 10 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Gun Shot Wound R. Temple

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Stock

(Duration) ..... yrs. ..... mos. ..... ds.

June 9/27 (Signed) G C Blades M. D.

19 (Coroner) (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where did disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 6/10 1927

20 UNDERTAKER: J. J. Moran ADDRESS 3006 Ballot

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 22999

CERTIFICATE OF DEATH.

38 E 22999

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 Brant St St., 9-4 Ward)

2-FULL NAME Doris May Sembly

(a) RESIDENCE NO. 607 Brant St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) March 17/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. md

PARENTS

10 NAME OF FATHER Ernst Sembly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Evlyn Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant Ernst Sembly

(Address) 607 Brant St

15 Filed JUN 10 1927 G. HAMPSON JONES, M. D. Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (type undetermined)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Probably Syphilitic)
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Price M. D.
(Coroner)

6/10/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauderbach Date of Burial June 11 1927

20 UNDERTAKER Samuel Easton ADDRESS 916 Pine

If the information is not complete, please supply it. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23000

CERTIFICATE OF DEATH

43 E 23000

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Edmondson & Swann Ave's. St. 28-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Austin Lowe Jenkins

(a) RESIDENCE NO. Edmondson & Swann Ave's St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 10 mos. 7 ds. How long in U. S. if of foreign birth 58 yrs. 10 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): August-2-1868

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	58	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER E. Austin Jenking

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Adelaide Victoire

13 BIRTHPLACE OF MOTHER (city or town) Frederick

(State or country) Maryland

14 Informant Miss. Mary Adelaide Jenkins (sister)

(Address) Edmondson & Swann Ave's.

15 Filed 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 9- 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to June 9, 1927, that I last saw him alive on June 9, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Cheek face,

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall B West, M. D.

June 10 1927 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: June-11-27 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH AVE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23001

E 23001

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Payne

(a) RESIDENCE NO. 1725 Fairmount St. Ward Wash. Co. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw R. Payne

6 DATE OF BIRTH (month, day, and year) Jan 22 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	57	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER James Martin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Eaton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to June 9, 1927, that I last saw her alive on June 9, 1927, and that death occurred, on the date stated above, at 3.38 P m.

The CAUSE OF DEATH* was as follows:

Agitated depression began insidiously in Nov. 1926.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion (duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted

If not at place of death? Washington D. C

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dorothy S. Burdick, M. D.

6-10, 1927 (Address) John Hopkins Hosp Balt,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral Cem. Date of Burial: June 19 27

20 UNDERTAKER: Harry Gordon's Sons Co. ADDRESS: McCulloh & Eutaw Sts

JUN 10 1927

Reg.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23002

CERTIFICATE OF DEATH.

E 23002

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Hoover

(a) RESIDENCE NO. 2915 Q St. N.W. Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

Filed JUN 10 1927 C. HAMPSON JONES, M. D. Registrar

Per BCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1 1927 to June 10 1927,

that I last saw h. alive on June 10 1927,

and that death occurred, on the date stated above, at 12 35 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis (15 yrs)

Diabetic Gangrene (duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Vernon K. Norwood M. D.

June 16 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Date of Burial June 11 1927

20 UNDERTAKER George J. Smith ADDRESS Hollins 153 L

Spec.–7-17-26—A Co.—200 Bks.

(Curville)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23003

CERTIFICATE OF DEATH

90

E 23003

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. H-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Curville

(a) RESIDENCE NO. 160 N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred • yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER William Curville

11 BIRTHPLACE OF FATHER (City or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Curville

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant (Address) BALTIMORE CITY HOSPITALS Reads

15 Filed UN 10 1927 17 G. HAMPSON JONES, M. D. Registrar

Per CRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from September 11 1926 to June 9 1927.

that I last saw h[illegible] alive on June 8 1927.

and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and Primary Degeneration and Failure

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) G. Hampson Jones M.D.

June 9 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross	6/11 1927
20 UNDERTAKER Phil J. Herring	ADDRESS 2011 Eutaw

MARGIN RESERVED FOR BINDING

U. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23004

CERTIFICATE OF DEATH

90 E 23004

REGISTERED NO. 9446

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 E 30th St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy James Carroll

(a) RESIDENCE NO. 507 E 30th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Elizabeth J. Carroll

6 DATE OF BIRTH (month, day, and year): January 3rd 1859

7 AGE: Years 68 Months 5 Days 15 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): City Forester

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town): Harford Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Carroll

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ella Shanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md,

14 Informant: Elizabeth J. Carroll (Address) 507 E 30th St.

C. HAMPSON JONES, M. D. Registrar

Per RKH

JUN 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25th 1927 to June 8th 1927 that I last saw h[illegible] alive on June 8th 1927 and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

6/9/1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St John Cemetery Long Green — Date of Burial: June 11 1927

20 UNDERTAKER: George J. Rust — ADDRESS: 1735 Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

E 23005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1402 Gough St. 3-4 Ward)

2-FULL NAME John Tommenello

(a) RESIDENCE NO. 1402 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tommenello

6 DATE OF BIRTH (month, day, and year) Sept 15. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit $45

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Maggio

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Vincent Maggio

(Address) 1411 Gough St

G. HAMPSON JONES, M. D.

Registrar.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Stenosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

June 8/27 (Signed) G. C. Yates M. D.

(Coroner)

(Address) 143 N. Gay

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial June 11 1927

20 UNDERTAKER Wendell H. Lippel ADDRESS 3008 Edmondt

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 10 1927

Spec.—1-12-23—M&T—500 Bks.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23006

CERTIFICATE OF DEATH.

E 23006

1-PLACE OF DEATH

REGISTERED NO. 752

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Univ Hospital St. H-30 WARD)

2-FULL NAME Gertrude Calloway.

(a) RESIDENCE No. Harrington Del. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Cr.	M.

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of B. Thorpe Calloway

6 DATE OF BIRTH (month, day, and year) Jan 11-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrington Del.

PARENTS

10 NAME OF FATHER Philamon Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant B Thorpe Calloway (Address) Harrington Del.

15 JUN 11 1927 19 C. HAMPSON JONES, M. D. Registrar

For R C H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to June 10, 1927.

that I last saw h~~e~~r alive on June 10, 1927.

and that death occurred, on the date stated above, at 11 15 A m.

The CAUSE OF DEATH* was as follows:

Infectious Arthritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) E. R. Miller, M. D.

19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrington Del. DATE OF BURIAL Jan 11 1927

20 UNDERTAKER Harry A Witzke ADDRESS 1501 W Lombard St

Spec.—7-17-26—A Co.—200 Bks.

23007

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23007

CERTIFICATE OF DEATH

159-003

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert Sts S. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cochran Coursey

(a) RESIDENCE NO. 600 W 36th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Edward E Coursey

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Cochran

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Edward E. Coursey

(Address) 600 W. 36th St.

15 C. HAMPSON JONES, M. D.

Registrar

JUN 11 1927

Per RPA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 1927, to 6/10, 1927

that I last saw h[illegible] alive on 6/10, 1927

and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Septicemia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial June 11 1927

20 UNDERTAKER Mrs. J. N. Teufel & Son — ADDRESS 1111 W Lafayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23008 E 23008

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH Mt Hope Retreat REGISTERED NO. 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Morgan M. Campbell

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —— Single

6 DATE OF BIRTH (month, day, and year): Oct 27-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Peter Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mt Hope Records. (Address): Mt Hope.

15 Filed JUN 11 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to June 9, 1927.

That I last saw h[illegible] alive on June 9, 1927

and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis
(Nephritic abcess)

(duration) yrs mos 14 ds

CONTRIBUTORY (Secondary): Paranoid Psychosis.

(duration) 28 yrs — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood + Urine.

(Signed) Milton P. Ickes M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's New Ground DATE OF BURIAL: 6/13 1927

20 UNDERTAKER: Chas. F. Grant & Son ADDRESS: 1811 W. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

E 23009 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23009

CERTIFICATE OF DEATH.

129

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Ettinge St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Rawlings.

(Residence in Baltimore: No. 1622 Ettinge St. St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 21, (Month) (Day) 1873 (Year)

7-AGE, 54 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer No. 14
(b) General nature of industry, business, or establishment in which employed (or employer): Steamboat

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Daniel Rawlings

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co

12-MAIDEN NAME OF MOTHER Willie More

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Rawlings

(Address)

15-

Filed JUN 1 1927, 191... C. HAMPSON JONES, M. D.

Per ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 9th, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1927, to June 9th 1927, that I saw him alive on June 9. 1927, and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(Duration) 1 yrs. mos. ds.

(Signed) Chas Norton, M. D.

6/10/27, 191... (Address) 55 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 54 yrs. 1 mos. 17 ds. In the State 54 yrs. 1 mos. 17 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Here

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, June 11, 191...

20-UNDERTAKER A. L. Brown's Son ADDRESS 1610 W. Monument St.

MARGIN RESERVED FOR BINDING

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23010

HEALTH DEPARTMENT—CITY OF BALTIMORE

123E 23010

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 16-64

City of BALTIMORE: (No. Winnie St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm P. Preston

(a) RESIDENCE NO. 2544 Edmondson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward P. Weldon

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 58 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Schopf

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Louisa Wehrheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edward Weldon & husband (Address) 2544 Edmondson ave

15 Filed JUN 1 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 9, 1927, that I last saw h[illegible] alive on June 9, 1927, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis + Colitis + Peritonitis

Contributory (Secondary) Short (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 7-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial 6/13 1927

20 UNDERTAKER: John J Conner & Son ADDRESS 901 Hollins St

Spec.—1-10-21 M&T 1500 Bks.

E 23011 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23011

CERTIFICATE OF DEATH.

114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Park Ave ST.) 13-5 WARD)

2-FULL NAME. Elizabeth Troth Kemp

(a) RESIDENCE NO. 2001 Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 27-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Bartlett

(Address) 2001 Park Ave

15 Filed JUN 11 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to June 10, 1927.

that I last saw her alive on June 9, 1927.

and that death occurred, on the date stated above, at 2 40 A. m.

The CAUSE OF DEATH* was as follows:

Enteri-colitis -

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. F. Robinson M. D.

6-11. 1927 (Address) 836 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gallston Hayfd Co. Md DATE OF BURIAL June 13 1927

20 UNDERTAKER Chas. E. Isaac & Son ADDRESS Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 23012

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23012

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Altamont ST. 35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernardo Bastinelli

(a) RESIDENCE NO. 304 Altamont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Carmel Bastinelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Benedetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Lenin

(Address) 304 Altamont

15 Filed JUN 11 1927

G. HAMPSON JONES, M. D. Registrar

By RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to June 10, 1927,

that I last saw h alive on June 10, 1927,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, interstitial, chronic

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) L. A. Smith, M. D.

6/10, 1927 (Address) 320 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jun 13 1927

20 UNDERTAKER Wendell Offel & Son — ADDRESS 378 N

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 23013

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23013

74001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 S. Montford Ave ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Kalb

(a) RESIDENCE. No. 518 S. Montford Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Kalb

6 DATE OF BIRTH (month, day, and year): Feb 22, 1871

7 AGE: Years: + 56yrs | Months: 3 | Days: 18 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar factory

(c) Name of employer: Bowers Cigar Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Leonard Kalb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Fickles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: wife Anna Kalb

(Address) 518 S Montford Ave

JN 17 1927

C. HAMPSON JONES, M. D.

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June Jan. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from June Jan. 7, 1927, to Jan. 10, 1927, that I last saw h im alive on Jan. 10, 1927, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Hemorrhage)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ~~Cancer~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J Feingler, M. D.

6/10, 1927 (Address) 1020 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 13 1927

20 UNDERTAKER: Kendall Appelgson — ADDRESS: 318 [illegible]

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23014

CERTIFICATE OF DEATH.

181-001 E 23014

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Nowakowski

(a) RESIDENCE NO. 522 S. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Nowakowski

6 DATE OF BIRTH (month, day, and year) Feb-1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Decorating Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER xxxxxxxxx

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Urban

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs X. Kwoka

(Address) 636 S. Lakewood Ave

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Probably Accidently

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

6/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Date of Burial June 11 1927.

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St

JUN 11 1927

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23015

CERTIFICATE OF DEATH.

E 23015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1813 W Pratt St. 19-24 Ward)

2-FULL NAME Andrew Lauffer

(a) RESIDENCE NO. 1813 W Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lauffer

6 DATE OF BIRTH (month, day, and year) Aug 16, 1864

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
62	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 50

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary Lauffer

(Address) 1813 W. Pratt St

15 Filed JUN 11 1927, 19 A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9. 1927

17 I HEREBY CERTIFY, That I attended deceased from Apl 10 1927, to June 9, 1927, that I last saw h[illegible] alive on June 8, 1927 and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Stricture of oesophagus (probably malignant)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of c

Was there an autopsy? no

What test confirmed diagnosis? c

(Signed) P. Gustav Dill, M. D.

6/11. 1927 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial June 11, 1927

20 UNDERTAKER Chas. W. Dill. ADDRESS 3109 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23016

E 23016

CERTIFICATE OF DEATH.

REGISTERED NO. 3

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1129 Pennington Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Garreis

(a) RESIDENCE. NO. 1120 Pennington Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Garreis

6 DATE OF BIRTH (month, day, and year): May 1st 1903

7 AGE: Years 24 Months 1 Days 8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Albert Yirka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Sophia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

11 Informant (Address): Michael Garreis 1120 Pennington Ave

15 FILED JUN 17 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1927. to June 9th 1927.

that I last saw her alive on June 7th 1927.

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam & Xrayed at Johns Hopkins Hospital

(Signed) Thos. D. Norton, M. D.

June 9th 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: June 13 1927

20 UNDERTAKER: Frank Crockson — ADDRESS: 1906 Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

23017

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23017

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 6-9 REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Ely

(a) RESIDENCE NO. 2344 Edmonson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE: Years 80 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Cullison

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS Records

(Address) [redacted]

15 [redacted] 19[redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30 1927 to June 10 1927

that I last saw h[redacted] alive on June 10 1927

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Myocarditis & Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Grant M. D.

June 11 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in d[redacted]auses, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: May 11 1927

20 UNDERTAKER: J. S. Mitchell — ADDRESS: 1900 Eutaw

JUN 11 1927

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 23018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 101 Poplar ave overlea St. 16-1 Ward)

2-FULL NAME Martha J. Jackson

(a) RESIDENCE NO. 3205 Dillon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David F. Jackson

6 DATE OF BIRTH (month, day, and year) Nov 21 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William E. Glass

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary E. Gough

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant David F. Jackson

(Address) 3205 Dillon St.

15 JUN 11 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10 , 1927 to June 9 , 1927

that I last saw h[illegible] alive on June 8 , 1927,

and that death occurred, on the date stated above, at 6-40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M. J. Davidson, M. D.

, 19 (Address) 3035 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Park Wood Cem. June 11 1927

20 UNDERTAKER — ADDRESS

Wm. C. Black 927 N. Broadway

P. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

E 23019 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 526 Lambert St. Ward) 17-24 31

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Foote

(a) Residence No. 526 Lambert St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar. 15-1885

7-AGE. 41 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer). At home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). D.C.

PARENTS.

10-NAME OF FATHER. Not stated

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not stated

12-MAIDEN NAME OF MOTHER. Amanda Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

11- (Informant) Samuel Foote (Husband)

(Address) 526 Lambert St.

15- Filed JUN 11 1927, 192 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9 1927

17- I HEREBY CERTIFY, That I attended deceased from April 2 1927 to June 9 1927

that I last saw her alive on June 9 1927

and that death occurred, on the date stated above, at 10 11 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F. Clauser M. D.

June 10 1927 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Md. Auburn Cem. DATE OF BURIAL. June 12 1927

20-UNDERTAKER. J. & M. Johnson ADDRESS 1284 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23020

CERTIFICATE OF DEATH.

129

E 23020

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. (STREET) 1668 (WARD)

2-FULL NAME Wm Spriggs.

(a) RESIDENCE NO. New Market Md. STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) New Market Md.

PARENTS

10 NAME OF FATHER Bill Spriggs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) West Balt. Gen. Hosp.

15 Filed JUN 11 1927 C. HAMPSON JONES, M. D., Registrar. Per RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/6, 1927, to 6/10, 1927.

that I last saw h alive on 6/10, 1927

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chas L Worley

(Signed) Chas L Jensen M.D.

6/10, 1927 Address West Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Market Md. DATE OF BURIAL: July 13 1927

20 UNDERTAKER: W E Falconer. ADDRESS: New Market.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 23021 (8th) E 23021

CERTIFICATE OF DEATH

1-PLACE OF DEATH: Southern Home — REGISTERED NO. C

CITY OF BALTIMORE (No. Greenmount Ave near 26th St. 12-50 WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Mrs Henrietta Vannaee (Harriet Frinette Van Namee)

(Residence in Baltimore: No. Southern Home St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (If wife the word): Widow

6-DATE OF BIRTH: September 20, (Month) (Day), 1851 (Year)

7-AGE: 75 yrs. 8 mos. 22 ds. (21) — If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Pittstown, N. Y.

PARENTS

10-NAME OF FATHER: Simeon Van Namee

11-BIRTHPLACE OF FATHER (State or country): New York

12-MAIDEN NAME OF MOTHER: Anna -----

13-BIRTHPLACE OF MOTHER (State or country): New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myron Van Namee

(Address) 2301 Harlem Ave c/o Mrs. Alice E. Clark

15- C. HAMPSON JONES, M. D.

Filed JUN 11 1927 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 11 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to June 11 1927, that I saw h[er] alive on June 11, 1927, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans
Senility

(Duration) yrs. mos. ds

Contributory (SECONDARY) Cardiac Arterio

(Duration) yrs. mos. ds.

(Signed) Jno P Byerly M. D.

June 11th 1927 (Address) 304 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pittstown, N. Y. — DATE OF BURIAL: 6/11/27

20-UNDERTAKER: J & B Cook — ADDRESS: 503 Park St

Spec.—1-10-21—M&T—1500 Bks.

E 23022 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3458 Cardenas Avenue St.) (WARD) 8-45-90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Schultz

(a) RESIDENCE No. 3458 Cardenas Avenue St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Catherine M. Schultz

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gaither Estate Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Leslie N. Collins (Address) 3458 Cardenas Avenue

15 Filed JUN 11 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 9, 1927, that I last saw h alive on June 8, 1927, and that death occurred, on the date stated above, at 7 35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) yrs 6 mos. ds.

CONTRIBUTORY (Secondary)* Bronchial Pneumonia

Terminal (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no,

What test confirmed diagnosis?

(Signed) E. H. Donally M. D.

6/9, 1927 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redemer — DATE OF BURIAL 6/13 1927

20 UNDERTAKER [illegible] Bloom — ADDRESS 1503 W. Baltimore S

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23023

CERTIFICATE OF DEATH.

161-001

E 23023

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 W. Franklin St ST.) 4-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Beatrice Davis

(Residence in Baltimore: No. 203 W Franklin St.

St.: 0 yrs. 2 mos. ? ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1927 (Year)

7-AGE, 0 yrs. 0 mos. ds.

If LESS than 1 day, 0 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Wesley Davis

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Beatrice Hawley

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed JUN 11 1927, C. HAMPSON JONES, M. D. D.H. Per CAH Registrar.

1411

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1927, to June 6 1927, that I saw h alive on June 6 1927, and that death occurred, on the date stated above, at 3.30A m.

The CAUSE OF DEATH* was as follows:

Premature Labor.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Lestandberry M. D.

, 191... (Address) 103 E Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL

Bureau of Vital Statistics JUN 11 1927

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23024

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH Franklin Sq Hospital — 161-001

CITY OF BALTIMORE: NO. ST. (OR AVE.) WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Crane

(a) RESIDENCE. NO. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
infant

6 DATE OF BIRTH (month, day, and year) 6/8/27

7 AGE Years Months Days If LESS than 1 day, 17 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City, Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Wilson Crane

11 BIRTHPLACE OF FATHER (city or town) Lake Odessa
(State or country) Michigan

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) Culpeper
(State or country) Va

14 Informant
(Address)

15 Filed JUN 1 1927 C. HAMPSON JONES, M. D. Registrar
Per RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/8, 1927, to 6/5, 1927, that I last saw her alive on 6/5, 1927, and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W W Quinn M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL
Department of Health

Spec.-7417-26—A Co.—200 Bks.

E 23025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23025

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 90

City of BALTIMORE: (No. 4 N. Magnolia Ave St. Hamilton 7-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Daniel J. O'Sullivan

(a) RESIDENCE NO. 304 N. Magnolia Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 2 mos. 23 ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia A. O'Sullivan

6 DATE OF BIRTH (month, day, and year): March 27 1876

7 AGE: Years 51 Months 2 Days 13 23

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Captain Balto. City F. D.

(b) General nature of industry, business, or establishment in which employed (or employer): Fire Dept. 032

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Daniel O'Sullivan

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth McAllister

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Mrs. Julia A. O'Sullivan

(Address) 304 N. Magnolia Ave

15 JUN 11 1927 C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 10

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1926, to June 10, 1927, that I last saw h[illegible] alive on June 5 1927, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Hampson Jones M. D.

6/10/27 (Address) 4702 Hamilton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemy Date of Burial: June 13 1927

20 UNDERTAKER: Henry Hoen Sons ADDRESS 1301 E Eager

FOR.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-00

E 23026

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospls

City of BALTIMORE: (No.) Balto Md. St. 1420 Ward)

2-FULL NAME Sydney K. Turner

(a) RESIDENCE NO. 2009 Druid Hill Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Turner

6 DATE OF BIRTH (month, day, and year) 1862 ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Boyd

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Kyle Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Balto City Hospls

(Address) Balto Md

Filed JUN 1 1927 C. HAMPSON JONES, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6-8-27

17 I HEREBY CERTIFY, That I attended deceased from 5-25- 1927, to 6-8- 1927, that I last saw her alive on 6-8- 1927, and that death occurred, on the date stated above, at 10.15 A.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry H. Colburn M. D.

, 19 (Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. W. Auburn Date of Burial 6/11/1927

UNDERTAKER Mrs. Geo. E. Holland ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23027

CERTIFICATE OF DEATH.

E 23027

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3710 E. Pratt St., 26-37 Ward)

2-FULL NAME Charlotte May Smith

(a) RESIDENCE NO. 3710 E Pratt St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8-1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER George W. Smith

11 BIRTHPLACE OF FATHER (city or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ruth Morse

13 BIRTHPLACE OF MOTHER (city or town): Balto Md.

(State or country)

14 Informant: George W. Smith

(Address) 3710 East Pratt St

15 Filed JUN 11 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:*

Accidental Asphyxia

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

Duration: yrs. mos. ds.

(Signed) G C Hampson Jones M. D.

(Coroner)

6/11/27 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Matthias Cem. Date of Burial June 11 1927

20 UNDERTAKER: Lilly & Zeiler Co ADDRESS 402 So. Wolfe

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23028

CERTIFICATE OF DEATH.

E 23028

89

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3218 O Donnell St. 26-1 Ward)

2-FULL NAME Maryanna Krol-

(a) RESIDENCE NO. 3218 O Donnell St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Krol

6 DATE OF BIRTH (month, day, and year) Sept 6 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionary

(b) General nature of industry, business, or establishment in which employed (or employer) Store 019

(c) Name of employer Self

9 BIRTHPLACE (city or town)_____

(State or country) Poland

PARENTS

10 NAME OF FATHER George Zaczek

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Jeziorska

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Poland

14 Informant Peter Krol

(Address) 3218 Odonnel St

15 Filed 19 G. HAMILTON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

(Signed) J C Pates M. D.

(Coroner)

11/21 19 (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary Cem	June 13 1927

20 UNDERTAKER John W. Weber ADDRESS 1203 Bank

1 1927

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co—200 Pks.

JOHN JACOBS

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23029

CERTIFICATE OF DEATH.

E 23029

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ____ St. ____ Ward) 9-46

2-FULL NAME John Jacobs

(a) RESIDENCE NO. 1639 Montpelier St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-10-26

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER John Jacobs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 JOHNS HOPKINS HOSPITAL

Informant

(Address) Records

15 June 1927 Registrar ROH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 10, 1927, that I last saw h.... alive on June 10, 1927, and that death occurred, on the date stated above, at 10:5[illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. P. Rothman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 11 1927

20 UNDERTAKER Chenoweth & Son ADDRESS 3417 Chestnut Ave

N 1

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 131 E 23030

1-PLACE OF DEATH Mercy Hospital. REGISTERED NO.

City of BALTIMORE: (No. 4-7 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madilda Learston

(a) RESIDENCE NO. Chestertown St., Maryland Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard C. Learston

6 DATE OF BIRTH (month, day, and year): October 14, 1877

7 AGE: Years 49 Months 7 Days 27

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown Md

(State or country)

PARENTS

10 NAME OF FATHER N. T. Edwards

11 BIRTHPLACE OF FATHER (City or town) (State or country) New Castle, Del.

12 MAIDEN NAME OF MOTHER Maslin

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Chestertown Md

14 Informant (Address) Richard Learston Chestertown Md

15 Filed JUN 12 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 19 27 to June 11 . 19 27

that I last saw h e alive on June 11 19 27 .

and that death occurred, on the date stated above, at 345 P. m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) H. Motta, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Md — Date of Burial: June 11 1927

20 UNDERTAKER: Wilbur W Thomas — ADDRESS: 1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—12-9-25—A Co.—200 Pks.

E 23031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1729 E 23031

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1458 William St. 1433 (Ward)

2-FULL NAME Sylvester P. Norfolk

(a) RESIDENCE NO. 1458 William St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma E. Norfolk

6 DATE OF BIRTH (month, day, and year): 2.21.1854

7 AGE: Years 73 | Months 2 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John N Norfolk

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Benton

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs Emma E. Norfolk

(Address) 1458 William St.

15 Filed JUN 2 1927 6 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6.11 1927

17 I HEREBY CERTIFY, That I attended deceased from 4.10 1927, to 6.11 1927, that I last saw he alive on 6.11 1927, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (from history) 1 yrs. (2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. F. Turlington, M. D.

6.11 1927 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — Date of Burial: 6/13 1927

20 UNDERTAKER: J. F. McCully — ADDRESS: 130 E. Fort Ave

WRITE PLAIN. USE INDELIBLE INK—This is a PERMANENT record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-0021

E 23032

REGISTERED NO. E 23032

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

~~E 23032~~ DEATH

City of BALTIMORE: (No. 922 S. Potomac St. 1-1 Ward)

2-FULL NAME Andrew Hasenei

(a) RESIDENCE NO. 922 S. Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1924

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER John Hasenei

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Sinclair

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant John Hasenei

(Address) 922 S. Potomac St

Filed JUN 12 1927 H. M. ROBERTSON, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3 1927 to June 11 1927, that I last saw him alive on June 10 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (tonsillar)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronuspas M. D.

6-11-27 (Address) 3037 O Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — Date of Burial June 12 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 23033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 23033

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 Primrose Ave St.) (Ward) 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Bentz

(a) RESIDENCE NO. 4 Primrose Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Bentz

6 DATE OF BIRTH (month, day, and year): Aug. 15 1851

7 AGE: Years 75 Months 9 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Melchor Harris

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Josephine Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Carroll France

(Address): 4 Primrose Ave.

15 Filed 19 Registrar

JUN 12 1927 C. HAMS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 9- 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 1925 to June 9 1927

that I last saw her alive on June 9 1927

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Uraemia Interstitial Nephritis

(duration) 4? yrs. mos. da.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) 1½ yrs. mos. da. to my knowledge

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Owen Russell, M. D.

6-10-27 (Address) 3902 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leisters Cemetery Carroll Co Md

Date of Burial: 6/13 19

20 UNDERTAKER: Wm Cook

ADDRESS: 532 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23034

CERTIFICATE OF DEATH.

E 23034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 217 N. Carrollton Ave (St.) (Ward) 18-16

2-FULL NAME Raymond Emory

(a) RESIDENCE NO. 217 N. Carrollton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 4, 1892

7 AGE — Years: 34 — Months: 8 — Days: 5. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): O'Tel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Samuel Emory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ida Holland

(Address): 217 N Carrollton Ave

15 Filed JUN 12 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927. to June 9 1927.

that I last saw him alive on June 9 1927.

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? regular

(Signed) W. F. Hobbs M. D.

(Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem DATE OF BURIAL: June 12 1927

20 UNDERTAKER: Samuel Kinsloe ADDRESS: 2 E Lee

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23035

CERTIFICATE OF DEATH.

E 23035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bal Gen Hosp 11-24-88 Ward)

2-FULL NAME Chas A Smith

(a) RESIDENCE NO. 336 Canal St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE: Years 48 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town):

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Smith.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Thayer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant: Corner Rolling

(Address) 574 St. Mary's St

15 Filed ..... 19..... A. M. .....

Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1892

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: R R Car Accident

Multiple Fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

6/9/92 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial 6/12 92

20 UNDERTAKER: Samuel Brumley ADDRESS 72 Belle

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 2 1892 HAMILTON, MD.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23036

CERTIFICATE OF DEATH.

E 23036
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. ST. 5-67 WARD)

2-FULL NAME Mrs Emma Lyons

(a) RESIDENCE No. 2905 Walbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James P. Lyons

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Wife (Address) West Baltimore Gen. Hosp

Filed JUN 12 1927 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/19, 1927, to 6/9, 1927, that I last saw him alive on 6/9, 1927, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder (Primary)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Post operative parotid sinus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/23/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Arnold L. Jensen M. D.

6/9, 1927 (Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 6-13 1927

20 UNDERTAKER: D. H. Brannan & Son

ADDRESS 517 N Schroeder St

IMPORTANT—Should be carefully examined. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23037

CERTIFICATE OF DEATH

E 23037

1-PLACE OF DEATH Union memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd + Cabert St. 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William H Brockman

(a) RESIDENCE NO. 2731 Alameda ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 50 mos. 8 ds. 17 How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Brockman

6 DATE OF BIRTH (month, day, and year): aug 27 1877

7 AGE: 49 Years 8 Months 17 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Brockman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Christine Lauterbach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Lillian M Brockman

(Address) 2731 Alameda Blvd

15 Filed JUN 12 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8 19 27 to June 10 19 27

that I last saw him alive on June 10 19 27

and that death occurred, on the date stated above, at 8 pm

The CAUSE OF DEATH* was as follows:

Carcinoma tongue c recurrence to glands neck left about 18 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia (doration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 6-8 27

Was there an autopsy? no

What test confirmed diagnosis? Pathological Study

(Signed) R J Belford, M. D.

(Address) Union memorial Hospital 6-10-1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park bur

Date of Burial: June 13 1927

20 UNDERTAKER: W M Routson

ADDRESS 2238 W Mt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23038

CERTIFICATE OF DEATH.

90 E 23038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 927 Gorsuch Ave. ST., 4-46 WARD)

2-FULL NAME Jane McKinley.

(a) RESIDENCE NO. 927 Gorsuch Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 10. 1856

7 AGE: Years 71 Months 5 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia Penna.

PARENTS

10 NAME OF FATHER: Michabel McKinley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rachel McAtee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Emma McKinley

(Address): 927 Gorsuch Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

JUN 2 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11- 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1- 1927, to June 11- 1927, that I last saw h alive on June 10- 1927, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Revel Brown, M. D.

6/11 1927 (Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: June 14 1927

20 UNDERTAKER: W M Rountree

ADDRESS: 2238 W North

Spec.—12-9-25—A Co.—200 Bks.

E 23039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 23039 REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1629 Poplargrove St. 16-68 Ward)

2-FULL NAME Savilla Striewig

(a) RESIDENCE NO. 1629 Poplargrove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Striewig

6 DATE OF BIRTH (month, day, and year) April 17 35

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	92	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER John Mark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Craig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant C A Skinner

(Address) 1629 Poplargrove

15 Filed JUN 12 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 12 27

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1927, to June 11th, 1927, that I last saw h.er alive on June 11th, 1927, and that death occurred, on the date stated above, at 12.40a. m.

The CAUSE OF DEATH* was as follows:

Diabetes and Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isaac C Dickson, M. D.

June 12 19 27 (Address) 3055 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bcm Date of Burial June 14 1927

20 UNDERTAKER W M Rountree ADDRESS 2238 N Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.–7-17-26—A Co.—200 Bks.

E 23040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23040

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hospital

City of BALTIMORE: (No. 13-32 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James Kenny

(a) RESIDENCE NO. 1009 W 40th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 0 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Alexia Kenny

6 DATE OF BIRTH (month, day, and year) Mar 29 1879

7 AGE	Years	Months	Days
	48	2	18

IF LESS than 1 day ..... hrs. or ..... min.

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Chas H Kenny

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Hospital Records

Filed JUN 13 1927, 19 . . . C. HAMPTON JONES, M. D. Registrar

By K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 11, 1927, that I last saw him alive on June 11, 1927, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Chronic diffuse nephritis

(duration) Not known yrs. mos. ds.

CONTRIBUTORY Diabetes & Uremia

(Secondary)

Coma (duration) yrs. mos. 3 ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

6/11, 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem Ferndale Date of Burial 6/14 1927

20 UNDERTAKER J Walter Laure ADDRESS 330 Paca St

IMPORTANT—PRINT WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23041

CERTIFICATE OF DEATH.

E 23041

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp. ST. 4-30 WARD)

2-FULL NAME Mary Lewis

(a) RESIDENCE NO. Sykesville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Lewis

6 DATE OF BIRTH (month, day, and year) July 3, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Springfield Hospital

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Rhuebottom

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Thomas Lewis (Address) Sykesville Md

15 Filed JUN 13 1927 19 Per H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to June 12 1927, that I last saw h[illegible] alive on June 12, 1927, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis 15 days.
Ruptured Appendix ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E Sermeller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Rock Md. DATE OF BURIAL June 15 1927

20 UNDERTAKER J. W. Cook ADDRESS 507 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23042

1-PLACE OF DEATH

CERTIFICATE OF DEATH

129 E 23042

REGISTERED NO.

CITY OF BALTIMORE: (No. 716 Reservoir ST., 13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes J. Stubbs

(a) RESIDENCE No. 716 Reservoir ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced (or) WIFE of Laurence Smith Stubbs

6 DATE OF BIRTH (month, day, and year) Oct. 11-1847

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
79	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Foster Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth C. Spaulding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant W. E. Stubbs (Address) 716 Reservoir St

15 Filed JUN 13 1927 19 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1923 to June 11 1927.

that I last saw h alive on June 11 1927

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis.

(duration) 4 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. 3 mos.

18 Where was disease contracted if not at place of death? 716 Reservoir St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Jack M. Spurgeon, M. D.

6/11 1927 (Address) 6 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL June 13 1927

20 UNDERTAKER Chas. E. Franck & Son ADDRESS Madison St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23043

CERTIFICATE OF DEATH.

113 E 23043

REGISTERED NO...

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 Herkimer (St.) 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry V. Fiorentina

(a) RESIDENCE. No. 1309 Herkimer St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 30, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Vincent Fiorentina

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa.

12 MAIDEN NAME OF MOTHER Margaret Bonfili

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Vincent Fiorentina
(Address) 39 Herkimer st

15 Filed JUN 13 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 11, 1927, that I last saw him alive on June 10, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) J. L. Dann, M. D.

6/11, 1927 (Address) 704 N. Charles St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 13 19 27

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23044

CERTIFICATE OF DEATH

129

E 23044

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 3307 E Baltimore St. 26-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick F. Stocker

(a) RESIDENCE NO. 3307 E Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male / Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma S. Miller

6 DATE OF BIRTH (month, day, and year) April 8 - 1879

7 AGE Years 48 Months 2 Days 6 IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Andrew Stocker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Goebel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Emma S Stocker

(Address) 3307 E Baltimore St

15 Filed JUN 13 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per K.J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 - 1927

17 I HEREBY CERTIFY, That I attended deceased from April 16 1927 to June 10 1927, that I last saw him alive on June 10 1927, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis Interstitial insufficiency

(duration) 9 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Strikol M. D.

, 19 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem — Date of Burial June 13 1927

20 UNDERTAKER John Merrick — ADDRESS 2008 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Towles 1432 William St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23045

CERTIFICATE OF DEATH.

E 23045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Boyle St. 24-34 WARD)

2-FULL NAME Mrs Bell

(a) RESIDENCE No. 1534 Boyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bell

6 DATE OF BIRTH (month, day, and year): Sept 9th 1863

7 AGE: Years 63 | Months 9 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): B.C.A.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frankland Md

PARENTS

10 NAME OF FATHER: Thos Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rebecca Wastes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Margaret Bell

(Address): 1534 Boyle St

15 Filed JUN 13 1927 Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from 10.4.27, 19 to 6.10.27, 19

that I last saw him alive on 6.9.27, 19

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Phillip B. Towles, M. D.

6.13.27 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: June 15th 1927

20 UNDERTAKER: H.D. Wishart

ADDRESS: 150 N Bond St

Alvina Kindt

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

203771

E 23046 — 1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

57

25-72

E 23046 — REGISTERED NO.

City of BALTIMORE: (No. _____ St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina Kindt

(a) RESIDENCE NO. 2503 Belmont Ave Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-11-78

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Conrad Alemans

11 BIRTHPLACE OF FATHER (city or town) Ger

(State or country)

12 MAIDEN NAME OF MOTHER Sophie Alemans

13 BIRTHPLACE OF MOTHER (city or town) Ger

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 Filed JUN 3 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17

I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 10, 1927, that I last saw h.er. alive on June 10, 1927, and that death occurred, on the date stated above, at 2:25 p.m.

The CAUSE OF DEATH* was as follows:

Otitis media, mastoiditis, acute, suppurative right, & Meningitis, , acute

(duration) yrs. mos. 2 ? ds.

CONTRIBUTORY (Secondary) Diabetes mellitus, ? ? ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 9th 1927

Was there an autopsy? yes

What test confirmed diagnosis? clinical examination

(Signed) Watt W. Eagle M. D.

6/10. 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial June 11, 1927

20 UNDERTAKER Chas. W. Dill. ADDRESS 3109 Fredk. Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Clara Ruth Boyd

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23047

E 23047

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 12-49

City of BALTIMORE: (No. 33d & Calvert St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hugh Boyd (Clara)
527 16th St.

(a) RESIDENCE NO. New Cumberland, Pa. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Hugh Boyd.

6 DATE OF BIRTH (month, day, and year): Feb. 4, 1874

7 AGE: Years 53 Months 4 Days 8

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Pennsylvania

(State or country)

PARENTS

10 NAME OF FATHER: Warren Miller

11 BIRTHPLACE OF FATHER (City or town): Pa.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Bross

13 BIRTHPLACE OF MOTHER (city or town): Pa

(State or country)

14 Informant: Hospital Records

(Address)

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 12, 1927

that I last saw her alive on June 12, 1927

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum with metastasis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Myocardial failure acute - several days

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 6/9/27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. S. Hammak, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cumberland Pa — Date of Burial: June 15 1927

20 UNDERTAKER: Harry A. Weitz & Co — ADDRESS: 1531 W. Lombard St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23048

31 E 23048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 30-30 St. E.B.T. Ward)

2-FULL NAME Ernest Pinder

(a) RESIDENCE NO. 620 Barre st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Pinder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Campher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 12, 19 27, to June 9, 19 27,

that I last saw him alive on June 9, 19 27,

and that death occurred, on the date stated above, at 6.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlin, M. D.

6-10-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 6-13 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23049

CERTIFICATE OF DEATH.

166

E 23049

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2705 West Balto. Gen. Hosp. St., 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Betts

(a) RESIDENCE NO. 2705 Garrison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Betts

6 DATE OF BIRTH (month, day, and year): Feb 3-1871

7 AGE — Years: 56 Months: 4 Days: 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country): Md

PARENTS

10 NAME OF FATHER: Geo H Clark

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary E Johnson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto

14 Informant: John F Betts

(Address): 2705 Garrison Ave

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Bichloride of mercury.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

June 14, 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial: June 13 1927

20 UNDERTAKER: H. J. Tschudy & Son ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23050

CERTIFICATE OF DEATH.

E 23050

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2742 E. Balto. St. 9-Wd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Stevens

(a) RESIDENCE NO. 1626 Chilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24/1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Woodall Co

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm F. Stevens

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary F. Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant Mrs. Edward H. Todd

(Address) 1626 Chilton St

15 Filed JUN 13 1927 G. HAMPSON JONES, M. D. Registrar

Per A K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Senility)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) _____

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Mates M. D.

(Coroner)

6/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial June 13 1927

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23051

CERTIFICATE OF DEATH

E 23051

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Nave.

(a) RESIDENCE NO. 1106 Forest Ave Charleston West Virginia St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married.

5a ~~Unmarried, Widowed, or Divorced~~ HUSBAND of (or) ~~WIFE of~~ Frances O Starr

6 DATE OF BIRTH (month, day, and year): April 15, 1886

7 AGE: Years 41 Months 1 Days 24 IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER Geo H. Starr

11 BIRTHPLACE OF FATHER (City or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER Edda Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant Mrs. Frances O Starr

(Address) Charleston W Va.

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927 to June 12 1927.

that I last saw him alive on June 12 1927.

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.
Metastasis to Liver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 31 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James W. Nelson M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston W Va Date of Burial: June 13 1927

20 UNDERTAKER: Wm L Tuttle ADDRESS: Lewisburg

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23052

CERTIFICATE OF DEATH.

111-001

REGISTERED NO. E 23052

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balt. Gen. Hosp. ST. 6-16 WARD)

2-FULL NAME Wm Boyd

(a) RESIDENCE NO. 1608 Monfort ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant (Address): Wst Balt. Gen. Hosp Record

15 Filed JUN 13 1927 19 For C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/11 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/31 1927 to 6/11 1927

that I last saw him alive on 6/11 1927

and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Goitre ulcer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of splanchic Vessels & spleen (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? yes Date of 4/15/27

Was there an autopsy? yes - partial

What test confirmed diagnosis? clinical history

(Signed) Arnold L Jensen M. D.

6/11 1927 Address West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemty DATE OF BURIAL: June 14 1927

20 UNDERTAKER: J William G Schaeffer ADDRESS: 1816 Eutaw pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23053

CERTIFICATE OF DEATH

153 E 23053

REGISTERED NO.

E 23053
1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital St., 24-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Middleton B Lubes

(a) RESIDENCE NO. 1631 Bell. Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 10 mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Lubes

6 DATE OF BIRTH (month, day, and year) 9-6-1862

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	64	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter 15
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Laurel
(State or country) Md

PARENTS

10 NAME OF FATHER Fred Lubes

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Feather

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Hosp. Records
(Address)

JUN 13 1927

15 Filed ....., 19.... Registrar C. HARRISON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
6-10-27

17 I HEREBY CERTIFY, That I attended deceased from 6-3-27, 19..., to 6-10-27, 19...,
that I last saw h[illegible] alive on 6-10-27, 19...,
and that death occurred, on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Extensive Cellulitis left leg and thigh

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY Toxemia
(Secondary)

(duration) 2 yrs. ... mos. ... da.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? Yes Date of 6-4-27
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.
. 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ont Olivet — Date of Burial June 14 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Eutaw St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23054

E 23054

CERTIFICATE OF DEATH

REGISTERED NO. 124

1-PLACE OF DEATH

City of BALTIMORE: (No. 2203 W. Lafayette Ave Ward) 568

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert T. Forsythe

(a) RESIDENCE NO. 2203 W Lafayette Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Forsythe

6 DATE OF BIRTH (month, day, and year): Dec 3 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Balt City Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Robert T Forsythe

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Friendship, Calvert Co

12 MAIDEN NAME OF MOTHER: Harriett Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Mrs Mary A Forsythe

(Address) 2203 W Lafayette ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927 to June 9, 1927.

that I last saw him alive on June 9, 1927

and that death occurred, on the date stated above, at 11.52 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

6/14, 1927 (Address) 1 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — Date of Burial: June 13 1927

20 UNDERTAKER: John F Denny — ADDRESS: 915 Light St

JUN 13 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23055

E 23055

40

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Gaskins

(a) RESIDENCE NO. 1612 Prestman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Gaskins

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 083

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James H. Gaskins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) B

14 Informant Nanie Gaskins

(Address) 1612 Prestman St.

15 Filed ..... 19 C. HAMILTON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia-Extravasation of urine

Stricture of Urethra

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

6/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cedarcroft Cemetery June 27

20 UNDERTAKER ADDRESS

Wm. R. G. Elliott 1223 Eastern Ave

JUN 13 1927

Not should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

...ated EXACTLY. PHYSICIANS should state CAUSE ...erly classified. Exact statement of OCCUPATION is ...ate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23056

CERTIFICATE OF DEATH.

90 E 23056

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1373 N. Stricker St. Ward) 15-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Washington

(a) Residence No. 1373 N. Stricker St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Washington

6-DATE OF BIRTH (month, day and year) 1883

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer ....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Unknown

11- (Informant) Barbara Washington

(Address) 1373 N. Stricker

15- Filed JUN 13 1927 192 C. HAMPSON JONES, M. D. Registrar.

Per K K

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 10, 1927

17- I HEREBY CERTIFY, That I attended deceased from Apr 30 1927 to June 10 1927

that I last saw h— alive on June 10 1927

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows: Organic Heart Disease

(Duration) About 4 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? Clinical Evidence

(Signed) J. Garland Churchill M. D.

June 13, 1927 (Address) 1334 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pt Auburn DATE OF BURIAL. June 13 1927

20-UNDERTAKER. Virginia E. Brooks ADDRESS 1463 N. Carey St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23057

CERTIFICATE OF DEATH

E 23057

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St., (T. B.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard

(a) RESIDENCE NO. 300 N. Mount st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mamie William

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26 19 27, to June 12 19 27,

that I last saw him alive on June 12, 19 27,

and that death occurred, on the date stated above, at 10.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Collins, M. D.

6-12-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] National

Date of Burial 6/15 1927

20 UNDERTAKER Daniel Eastern

ADDRESS 916 Pmar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23058

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. E 23058

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. [redacted] St. [redacted] Ward)

2-FULL NAME Robert Scott

(a) RESIDENCE NO. 924 Pear Alley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER Albert Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed JUN 13 1927 19 C. HAMPSON JONES A. Registrar

By RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1927

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to June 8, 1927, that I last saw him alive on June 8, 1927, and that death occurred, on the date stated above, at 9:30 p m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and brain degeneracy

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General laboratory findings

(Signed) [redacted] M. D.

June 9 1927 Address BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial 6/13 1927

20 UNDERTAKER Dan Easton ADDRESS 916 Penna Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23059

CERTIFICATE OF DEATH.

E 23059

REGISTERED NO. 16-2-100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1438 W. Lanvale St. Ward 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen L. Keuk

(a) RESIDENCE NO. 1438 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1927

7 AGE: Years | Months 0 | Days 6 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Keuk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Brooks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Edward Keuk
(Address) 1438 W. Lanvale St.

15 Filed JUN 13 1927 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history of accident other disease (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Hamilton M. D.
(Coroner)

June 13, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the state ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery | Date of Burial: June 13 1927

20 UNDERTAKER: Mrs Katie R. Williams | ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 23060

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-021

E 23060

REGISTERED NO.

23060 PLACE OF DEATH

City of BALTIMORE: (No. B. & O. R. R. tracks, Howard & Ostend Sts. 24-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Do not know.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
About 50	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Do not know.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Do not know.

14 Informant: Police Report. S.D.

(Address)

15 Filed: G. HAMILTON JONES, M. D., Registrar

16 By: R.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over and mangled by B. & O. Co Engine. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto Leonhardt M. D.

(Coroner)

6/10 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lt Vincents — Date of Burial: June 13 1927

20 UNDERTAKER: Wendell J Lippel — ADDRESS: 300 E Cold

CAUTION.—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23061 — 1-PLACE OF DEATH

90E 23061

REGISTERED NO.

City of BALTIMORE: (No. 1223 E Jefferson St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Leicht

(a) RESIDENCE NO. 1223 E Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced: ~~HUSBAND of~~ (or) WIFE of Late Isaac Leicht

6 DATE OF BIRTH (month, day, and year): Sept 19 - 1865

7 AGE: Years 62 | Months 8 | Days 22 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: John Kirchner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Evan Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Louisa A. Birch

(Address): 1223 E Jefferson St

15 Filed JUN 13 1927 By [illegible] Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-10-27

17 I HEREBY CERTIFY, That I attended deceased from 6-7-, 1927, to 6-10-, 1927, that I last saw h(er) alive on 6-10, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Asthma and Endocarditis with Severe Dyspnea.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis & Dyspnea (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake M. D.

. 19 (Address) 1402 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shrewsbury Co. York Pa. Date of Burial: June 14 1927

20 UNDERTAKER: Jas C. Miller Jr. ADDRESS: 2334 Gilmor St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23062

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23062

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 6237 M4-001

City of BALTIMORE: (No. ..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Colic (also known as George Arthur Collie)

(a) RESIDENCE NO. Norris Farm, Stemmers Run St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years: 40 ? Months: ..... Days: ..... IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): ?
(State or country)

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town): .....
(State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): .....
(State or country): ?

14 Informant (Address): BALTIMORE CITY HOSPITALS Records

15 Filed JUN 13 1927 19 C. HAMPSON JONES, M. D. Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 8, 1927, that I last saw him alive on June 8, 1927, and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? general & laboratory

(Signed) R. Hoffman M. D.

June 8, 1927 BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... Date of Burial 19

20 UNDERTAKER ..... ADDRESS .....

IMPORTANT: BE SURE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 23063

CERTIFICATE OF DEATH.

E 23063

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 781 W. Lexington St. Ward)

2-FULL NAME Baby Shelton

(a) RESIDENCE NO. 781 W. Lex. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Name

6 DATE OF BIRTH (month, day, and year): 6/10/27

7 AGE — Years | Months | Days | IF LESS than 1 day, __ hrs. or __ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Walter Shelton

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Del

12 MAIDEN NAME OF MOTHER: Elizabeth Reichert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant

(Address)

15 Filed _____, 19__ G. HAMPSON JONES, M. D. Registrar

Per _____

1435

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/10/27

17

I HEREBY CERTIFY, That I attended deceased from 6/10, 19 27, to 6/10 27, 19 ____,

that I last saw h__ alive on 6/10/27, 19 ____,

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(History 6 hrs to 6 hrs)

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY

(Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death! — Date of

Was there an autopsy! —

What test confirmed diagnosis!

(Signed) Kennedy Terry, M. D.

6/11/1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

JUN 13 1927

Department of Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23064

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1038 N. Stricker St. Ward) 16-27

2-FULL NAME Wm. Henry Louden

(a) RESIDENCE NO. 1038 N. Stricker St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23, 1927

7 AGE: Years 18 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jarrett, (State or country) Md.

PARENTS

10 NAME OF FATHER John Louden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sally Louden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sally Louden

(Address) 1038 N. Stricker St.

Filed ....., 19.....

C. HAMPSON JONES, M. D.

Registrar

3 1927 1117

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured foramen ovale

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

June 10, 1927 (Address) 1602 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND JUN 13 1927

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23065

CERTIFICATE OF DEATH

129 E 23065

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1202 E Federal st. St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabell Williard.

(a) RESIDENCE NO. 1202 E. Federal st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond R. Williard.

6 DATE OF BIRTH (month, day, and year): 120 Jan. 12, 1890

7 AGE: Years 37 Months 4 29 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Sam Miller

11 BIRTHPLACE OF FATHER (City or town): Pa.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Pa.

(State or country)

14 Informant: Raymond R. Williard

(Address) 1202 E. Federal st.

15 Filed JUN 13 1927

16 C. HAMPSON JONES, M. D.

Registrar

Per RBB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1927, to June 11, 1927,

that I last saw h e alive on June 11, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetis M. Heart Life

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Val disease

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Sanderson, M. D.

, 19 (Address) 17 N Leander Jr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. Date of Burial: June 14 1927

20 UNDERTAKER: Geo. L. Pratt ADDRESS: 1135 Harford Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23066

CERTIFICATE OF DEATH

11

E 23066

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Kupfert

(a) RESIDENCE NO. 634 Gesquet St Balto. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kupfert

6 DATE OF BIRTH (month, day, and year) April 27. 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	54	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll County

(State or country)

PARENTS

10 NAME OF FATHER Owen Gilroy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth DeFord

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. L. Narramore

(Address) 1100 Hartford Ave

15 Filed JUN 19 1927 H. HARRISON JONES, M. D. Registrar

For AFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/8/27, 19 ... to 6/13/27, 19 ...

that I last saw h Er alive on 6/12/27, 19 ...

and that death occurred, on the date stated above, at 11 AM m.

The CAUSE OF DEATH* was as follows:

Appendicitis (perforated)

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted Home

If not at place of death? ...

Did an operation precede death? yes Date of 6/8/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. U. Mc Smith M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial 6/17 1927

20 UNDERTAKER George J Ruth — ADDRESS 1735 Hartford Ave

Non should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23062 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) 1-N (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Semenkow

(a) RESIDENCE NO. 29 S Robinson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Elizabeth Semenkow

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Wawro Semenkow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Elizabeth Semenkow

(Address) 29 S. Robinson St.

15 Filed 1 3 1927, 19 C. HAMPSON JONES, M.D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-27 19

17

I HEREBY CERTIFY, That I attended deceased from 6-9-27, 19 ... to 6-12-27, 19 ...

that I last saw him alive on 6-12-27, 19 ...

and that death occurred, on the date stated above, at 345 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes No Date of 6-10-27

Was there an autopsy?

What test confirmed diagnosis? Clinical + Labor

(Signed) C. V. Feaganden, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL June 14th 1927

20 UNDERTAKER Lilly + Zeiler — ADDRESS 4008 Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23068

CERTIFICATE OF DEATH.

E 23068

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Flynn

(a) RESIDENCE NO. North Point Rd & Cresent Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18/1909

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17 18	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John J. Flynn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Lena Pieper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Lena Pieper Flynn

(Address)

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis-Gangrenous Endometritis

(Autopsy at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Abortion self induced

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pilson, M. D.

(Coroner)

19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial June 14 1927

20 UNDERTAKER Lilly & Zieber Co ADDRESS 403 So Wolfe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23069

HEALTH DEPARTMENT—CITY OF BALTIMORE E 23069

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1415 Curtis Ave St., 25-77 (Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teofila Kowalewska.

(a) Residence No. 1405 curtis ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 50) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 17 1853

7-AGE. 73 yrs. 75 mos. 11 ds. 24 If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

11- (Informant) Helen Kosmatka

(Address) 1415 Curtis Ave

15- Filed 6-3 1927 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 1927 to June 11 1927

that I last saw h alive on June 5 1927

and that death occurred, on the date stated above, at 10 20 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon J. Hotek M. D.

June 13 1927 (Address) Curtis Bay Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lot Cross a.d.a. DATE OF BURIAL, June 14, 1927

20-UNDERTAKER, F W Ozagerwske ADDRESS 1930 Eastern ave

instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23070

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23070

CERTIFICATE OF DEATH.

159

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 1132 Hull St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Stanislawa Lesniewski

(a) Residence No. 1132 Hull St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Single

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 11, 1918

7-AGE. 9 yrs. 1 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.
10-NAME OF FATHER, Antoni Lesniewski
11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland
12-MAIDEN NAME OF MOTHER, Leokadja Frankowska
13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

14- (Informant Mrs Leokadja Frankowska
(Address) 1132 Hull St

15- Filed 3 1927 C. HAMPSON JONES, M. D. Registrar.
Per Lee

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11, 1927

17- I HEREBY CERTIFY, That I attended deceased from April 21, 1925 to June 11, 1927
that I last saw her alive on June 11, 1927
and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:
mitral regurgitation and aortic insufficiency
(Duration) 2 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) coronary occlusion
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? usual tests

(Signed) George Krupp M. D.
, 19 (Address) 3030 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary Cem. | DATE OF BURIAL, June 14 1927

20-UNDERTAKER. John M. Weber | ADDRESS 1803 Bank St

Please write, as that is way property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

Dr Hulbert 1927 Gough St ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23071

CERTIFICATE OF DEATH

90 E 23071

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1907 Gough St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sunderland

(a) RESIDENCE NO. 1907 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND (of) or WIFE (of): Beverly W. Sunderland

6 DATE OF BIRTH (month, day, and year): Aug 7, 1825

7 AGE: Years 101 Months 10 Days 6

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Edward Coleman

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Sarah Hinkel

(Address): 1907 Gough St

15 Filed: JUN 13 1927

C. HAMPSON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to June 13, 1927,

that I last saw her alive on June 12, 1927,

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) " yrs. " mos. " ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Geo. Uhler, M. D.

6/13, 1927 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem. Date of Burial: June 13 1927

20 UNDERTAKER: H. M. Cook ADDRESS: 527 E Monument

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Fashion 2405 Monument Ave.

Spec.–7-17-26—A Co.—200 Bks.

E 23072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23072

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 805 N Lakewood Ave St., 67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence E. Smith

(a) RESIDENCE NO. 805 N Lakewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlotte E. Smith

6 DATE OF BIRTH (month, day, and year): March 31, 1888

7 AGE — Years: 39 Months: 2 Days: 11 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Express Agent

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Am Ry. Express

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Charlotte E. Smith 805 N. Lakewood Ave

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1926 to June 12 1927, that I last saw h[illegible] alive on June 10 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) 3 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno Fashion, M. D.

6/13. 1927 (Address) 1823 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: June 15 1927

20 UNDERTAKER: J. W. Cook ADDRESS: 302 Elliott Ave

(Fill in all blanks. Information must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.–7-17-26—A Co.—200 Bks.

E 23073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23073

CERTIFICATE OF DEATH

92

28-65

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 21 Talbot Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha A. Levy

(a) RESIDENCE NO. 21 Talbot Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Levy

6 DATE OF BIRTH (month, day, and year) 1861 Oct. 22nd. ~~1927~~

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carlisle, (State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel Arnold,

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen Greenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mr. M. Gundersheimer

(Address) 21 Talbot Road

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per RCR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 12, 1927, that I last saw her alive on June 11, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis coronary artery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles I. Bustein M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. Date of Burial 6/14/ 1927

20 UNDERTAKER Baird Sondheim ADDRESS 1918 Madison Ave

DO NOT ABBREVIATE. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23074

CERTIFICATE OF DEATH

E 23074

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Georgian Court Apt 12-59 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmund Katz

(a) RESIDENCE NO. Linden Ave / Brookline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose K. Katz

6 DATE OF BIRTH (month, day, and year) June 21st 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	62	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General natore of industry, business, or establishment in which employed (or employer) Gents 045

(c) Name of employer Haberdasher

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Elias Katz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bethi —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Frank Katz

(Address) E. HAMPSON Georgian Ct.

15 Filed Apr 19 RKK Registrar

3 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1925 to June 12, 1927.

that I last saw h[illegible] alive on June 12, 1927.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ? stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of about June 15/25

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — Date of Burial 6/15 1927

20 UNDERTAKER David Sondheim — ADDRESS 1182 W. Lanvale St

(Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23075

CERTIFICATE OF DEATH

52

REGISTERED NO. E 23075

1-PLACE OF DEATH

City of BALTIMORE: (No.) Ridge Ave. and Cross Country Boulvd. (St.) (Ward) 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Hayden Grafflin

(a) RESIDENCE NO. Ridge Av-Cross Country Blvd St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 19 ds. How long in U. S. if of foreign birth? 69 yrs. 7 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOW

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Howard Grafflin

6 DATE OF BIRTH (month, day, and year) October-24-1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	69	7	19 (18)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Horace Hayden

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gillet

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. John H. Grafflin Jr., (son)

(Address) Ridge Av-Cross Country Blvd.

15 Filed JUN 13 1927 C. HAMPSON JONES, M. D. Registrar

Per RPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9 1927 to June 12 1927

that I last saw h-- alive on June 12 1927

and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Arthritis (duration) Many years yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Eakin M. D.

6/13/27 (Address) Wilmot Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — Date of Burial June-14 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 100 W. NORTH AVE.

...ld state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... very important. See instructions on back of certificates. ... of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23076

CERTIFICATE OF DEATH

90 E 23076

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1436-John-St. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Hyde

(a) RESIDENCE NO. 1436-John-St. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 74 yrs. 0 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret H. Hyde

6 DATE OF BIRTH (month, day, and year) May-17-1853

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	74	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Judge of the O[illegible]42

(b) General nature of industry, business, or establishment in which employed (or employer) Orphans' Court of

(c) Name of employer A.A.Co., Md.

9 BIRTHPLACE (city or town) A.A.Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Hyde

11 BIRTHPLACE OF FATHER (City or town) A.A.Co.,

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A.E.Bird

13 BIRTHPLACE OF MOTHER (city or town) A.A.Co.,

(State or country) Maryland

14 Informant Mr. J.F.B.Hyde (brother)

(Address) 1803 Bolton Street

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Fee ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from about 17 months ago to June 12, 1927

that I last saw him alive on June 12, 1927

and that death occurred, on the data stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis and arteriosclerosis

(duration) 1½ yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Symptoms and physical examination.

(Signed) L. F. Shemwell, M. D.

June 13, 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
West River, A.A.Co., Maryland	June-14-27
20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY, WILLIAM F. WOOSTER, Successor	136 W. NORTH AVE.

JUN 13 1927

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS & OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23077

E 23077

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 14-20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Carroll Rouse

(a) RESIDENCE NO. 251 Robert Street St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. 8 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Lillian C. Rouse

6 DATE OF BIRTH (month, day, and year) October, 9, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent Prohibition

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Government

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) Fauquier Co.,

(State or country) Va.

PARENTS

10 NAME OF FATHER Charles W. Rouse

11 BIRTHPLACE OF FATHER (city or town) Fauquier Co.,

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary W. Owens

13 BIRTHPLACE OF MOTHER (city or town) Stafford Co.,

(State or country) Va.

14 Informant Mrs. Lillian C. Rouse (wife)

(Address) 251 Robert Street

15 Filed ..... 19 ..... Registrar

1927 C. EMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-12-1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis and Sepsis due to a pistol shot wound of the stomach and Intestines Homicide (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt M. D. (Coroner)

6/18 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 0 yrs. 0 mos. 4 ds. In the State 3 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 251 Robert Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Ivy Hill Cemetery, Alexandra-Va June-14-27

20 UNDERTAKER — ADDRESS

STEWART & MOWEN COMPANY

IMPORTANT: PHYSICIANS ... code state cause. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23078

100-001

E 23078

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 634 N. Streeper St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris E. Harper

(a) RESIDENCE NO. 634 N. Streeper St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 18/25

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. R. Harper

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Genevie Witte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Wm. R. Harper

(Address) 634 N. Streeper St

15 Filed ..... 19.. C. HARRISON KELLY, M. D.

Registrar

Per

N 14 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/27 19..

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Secondary Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

6/13/27 19.. (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial June 14, 1927

20 UNDERTAKER John A. Moran ADDRESS 3002 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23079

E 23079

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital Loyalard & Greene Ward) 27-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Boy Scott

(a) Residence No. 805 Leadenhall St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 6-2-27

7-AGE. .....yrs. .....mos. 1 ds. If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer.....

9-BIRTHPLACE (city or town) ..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Edward Scott

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER. Stella Scott

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country). Maryland

11- (Informant).....

(Address).....

15- Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-3-27

17- I HEREBY CERTIFY, That I attended deceased from 6-2 1927 to 6-3 1927

that I last saw him alive on 6-3 1927

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Prolonged labor c Cephalic Disproportion

.....(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital

adelectasis (Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) Ezra F. Dodge, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cemetery Hosp. DATE OF BURIAL, ... 19....

20-UNDERTAKER, ... ADDRESS .....

instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23080

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23080

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Green St. 14-20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Jackson

(a) Residence No. 2024 Division St. St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6-9-27

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 8 hrs. or 35 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md. (State or Country)

PARENTS.

10-NAME OF FATHER, John Jackson

11-BIRTHPLACE OF FATHER (city or town) North Carolina (State or Country)

12-MAIDEN NAME OF MOTHER, Roberta Thomas

13-BIRTHPLACE OF MOTHER (city or town) North Carolina (State or Country)

14- (Informant)

(Address)

JUN 14 1927 HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6-9-27

17- I HEREBY CERTIFY, That I attended deceased from 6-9 1927 to 6-9 1927

that I last saw h. alive on 6-9 1927

and that death occurred, on the date stated above, at 10.43 a m.

The CAUSE OF DEATH* was as follows:

Maternal Sepsis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Ernest Dodge M. D.

, 19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. University - Hosp.

DATE OF BURIAL. ..... 19....

20-UNDERTAKER.

ADDRESS

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23081 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 23081

REGISTERED NO.

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor ST. 14-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Thomas

(a) RESIDENCE No. 2225 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James I Thomas

6 DATE OF BIRTH (month, day, and year): Unknown 1889

7 AGE: Years 38; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: James I Thomas (Address) 2225 Druid Hill Ave

15 Filed JUN 14 1927 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7 - 1927, to June 11 - 1927, that I last saw her alive on June 11 - 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Carcinoma of Uterus (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus + Gangrene (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Positive

(Signed) Dr. Hillman, M. D.

6-11-1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. DATE OF BURIAL: June 14 1927

20 UNDERTAKER: P. H. Elliott ADDRESS: 1705 Eutaw

TION is very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23082 — 1-PLACE OF DEATH

129 ✓

E 23082 — REGISTERED NO.

City of BALTIMORE: (No. 1106 Whatcoat St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M Hamilton

(a) RESIDENCE NO. 1106 Whatcoat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence Hamilton

6 DATE OF BIRTH (month, day, and year) 8-12-1874

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min..
53	53	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Colonia Fisher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Florence Hamilton

(Address) 1106 Whatcoat St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

JUN 4 1927 Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-1927

17 I HEREBY CERTIFY, That I attended deceased from 4-17-, 1927, to 6-12-, 1927,

that I last saw him alive on 6-11-, 1927,

and that death occurred, on the date stated above, at 11 45A.

The CAUSE OF DEATH* was as follows:

Nephritis (chronic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank A Saunders M. D.

, 19 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial June 6 1927

20 UNDERTAKER Clarence E Wright ADDRESS 1364 W Lexington

OF DEATH in plain terms, so that it may be very important. See instructions on back of

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23083

CERTIFICATE OF DEATH.

E 23083

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Hauser.

(a) RESIDENCE NO. Baltimore Highlands. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXd HUSBAND of XXXXXXXXXX Pearl Hauser.

6 DATE OF BIRTH (month, day, and year) February 22, 1904.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laster in shoe factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Hauser.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine Bryan.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Pearl Hauser. (wife)

(Address) 1166 N. Hamburg St.

15 Filed JUN 14 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Struck and knocked down by an automobile, jumped from a moving B.&O. & C. Car in front of automobile. (duration) Accidental Death. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

6/13 1927 (Address) 101½ E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Ecott St between Cross & Ostend Sts.

Former or usual residence June 1, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cemetery June 14 1927

20 UNDERTAKER ADDRESS

John F. Denny 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 23084

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23084

CERTIFICATE OF DEATH

× 38

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. 1 St. 47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Taylor

(a) RESIDENCE NO. St. Marys Co. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 67 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None — 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Edw Taylor

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Edw Taylor (Address) Tanyard Md

15 Filed ... 19 ... Registrar

JUN 14 1927 (CHAMPION JONES, M. D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 24 . 19 27 . to June 11 . 19 27 .

that I last saw him alive on June 11 . 19 27 .

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial 6/14/27

20 UNDERTAKER: Geo A Farley Sucsr ADDRESS 7 Fayette

Any attempt to carelessly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23085 CERTIFICATE OF DEATH. 384 **E 23085**

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N Bruce St. 14-27 Ward)

2-FULL NAME Susie Carter

(a) RESIDENCE NO. 503 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Div.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 41 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Rose Giles

(Address): 503 N Bruce

15 Filed....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to June 11, 1927, that I last saw h..... alive on June 11, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 5 mos. 20 ds.

CONTRIBUTORY (Secondary): Pulm. Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Howard, M. D.

(Address) June 12 1927 934 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial June 14 1927

20 UNDERTAKER: Samuel Easton ADDRESS 916 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 23086 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 23086

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (St.) (WARD) 27th

2-FULL NAME Joseph Hill

(a) RESIDENCE No. 651 W Lafayette ave (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs E Hill

(Address) 651 W Lafayette ave

15 Filed JUN 14 1927, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 11, 1927, that I last saw him alive on June 11, 1927, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John W. Gaines, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Balto DATE OF BURIAL June 14 1927

20 UNDERTAKER Daniel Easton ADDRESS 516 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23087 (upper right)

1-PLACE OF DEATH E 23087

CITY OF BALTIMORE: (No.) 1515 (St.) Mosher (Ward) 16-27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Johnson

(a) RESIDENCE NO. 1515 ST. Mosher WARD

(Usual place of abode) (If non-resident give City or Town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Isabelle Johnson

6 DATE OF BIRTH (month, day, and year) Jan. 1- 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer Carroll Coal Co. Oliver St

9 BIRTHPLACE (city or town) (State or country) West River Md.

PARENTS

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thomas Johnson

(Address) 1515 Mosher St

15 Filed JUN 14 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11- 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9- , 1927 , to June 11- , 1927 , that I last saw him alive on June 11- , 1927 , and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) not definately known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL June 14/1927

20 UNDERTAKER Harriet Easton — ADDRESS 916 Pa ave

HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Moore

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23088

CERTIFICATE OF DEATH.

74-001

E 23088
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 Myrtle ST. 17-24 WARD)

2-FULL NAME Wm. Moore

(a) RESIDENCE NO. 1015 Myrtle ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS
10 NAME OF FATHER Wm. Moore
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant: John Moore
(Address) 1015 Myrtle ave

16 Filed JUN 14 1927 HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to June 14, 1927, that I last saw h[illegible] alive on June 13, 1927 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Frank E. Wagner, M. D.
June 14, 1927 (Address) 1016 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 14/1927

20 UNDERTAKER: Daniel Carton — ADDRESS: 916 Mc

Spec.–7-17-26—A Co.—200 Bks.

E 23089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 23089

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 W Cross St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Hart

(a) RESIDENCE NO. 32 W. Cross St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Hart

6 DATE OF BIRTH (month, day, and year): autumn

7 AGE: Years 55 Months ? Days ? IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Ella Hart

(Address) 32 W. Cross St.

15 Filed JUN 14 1927 19 C. HAMPSON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/25/ 1927 to 6/14/ 1927

that I last saw h... alive on 6/11/ 1927

and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coma (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Hist. Or. Interstitial Nephritis (Syntic) (duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Microscop.

(Signed) ... M. D.

6/13/ 1927 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

Date of Burial: June 15 1927

20 UNDERTAKER: A. L. Brown's Son

ADDRESS: 108 N. Monty

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

CERTIFICATE OF DEATH.

E 23090 NUMBER OF DEATH

REGISTERED E 23090

City of BALTIMORE: (No.) 2204 York Rd St. 13-54 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 2204 Pocahontas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced. (~~write the word~~): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of: Adelia P Smith

6 DATE OF BIRTH (month, day, and year): April 28-1861

7 AGE: Years 56 Months 1 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Repair

(b) General nature of industry, business, or establishment in which employed (or employer): Janitor Apt. House

(c) Name of employer: Chicago

9 BIRTHPLACE (city or town): (State or country)

PARENTS

10 NAME OF FATHER: Robert B Smith

11 BIRTHPLACE OF FATHER (city or town): (State or country) Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Not Known

14 Informant: Edward J Smith

(Address) 1134 Montpelier St.

15 Filed....., 19..... Per..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (~~Autopsy~~ or Inquiry) thereon and from the evidence obtained by said Inquest (~~Autopsy~~ or Inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebro Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hosman M. D. (Coroner)

6/13, 19 27 (Address) 1432 Rolandale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County Date of Burial June 15 1927

20 UNDERTAKER: Wm C. Fuller & Son ADDRESS 2834 Pennsylvania Ave

C. HARRY JONES, M.

JUN 14 1927

IF DEATH IS from any VIOLENCE, state MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL OR HOMICIDAL. Write PLAINLY in ink. Use only such abbreviations as are in common use. Do not use ditto marks. Answer all questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—500 Bks.

E 23091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 23091

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 N Patterson Pk Ave Ward) 12

2-FULL NAME Mary Elizabeth Codd.

(a) RESIDENCE NO. 715 N. Patterson Park Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married,~~ Widowed, or ~~Divorced.~~ (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Late Benjamin Codd.

6 DATE OF BIRTH (month, day, and year) June 10-1844

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Lynch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Fairbanks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Emma Codd

(Address) 715 N Patterson Pk Ave

15 Filed JUN 14 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-27 19

17 I HEREBY CERTIFY, That I attended deceased from June 9 19 27 to June 11 19 27,

that I last saw h.. alive on June 11 19 27,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) [illegible], M. D.

6/12/27 (Address) 718 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: June 14 1927

20 UNDERTAKER: Wm. F. Miller & Son — ADDRESS: 2361 Eastern Ave

IF DEATH IS FROM VIOLENCE, state MEANS and NATURE of INJURY, as DROWNING, FALL, GUNSHOT WOUND, etc., and whether ACCIDENTAL, SUICIDAL or HOMICIDAL. BURIAL PERMITS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

24375 1

2 E 23092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 23092

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 8-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Mitchell

(a) RESIDENCE NO. 2807 Maryland St. use Ward City

(Usual place of abode) Overland. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin L. Mitchell

6 DATE OF BIRTH (month, day, and year): Sept 13. 1857

7 AGE: Years 69 | Months 9 | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Usa

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER: Geo. C Clapp

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Boston Mass.

12 MAIDEN NAME OF MOTHER: Elizabeth B. Myrennis

13 BIRTHPLACE OF MOTHER (city or town): JOHNS HOPKINS HOSPITAL

(State or country) Penna

14 Informant

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 19 27

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 13, 1927, that I last saw her alive on June 13, 1927, and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Suppression of Urine

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Visual Examination

(Signed) Grace Baker, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial June 15 19 27

20 UNDERTAKER: J. M. Cook — ADDRESS 502 E. North Ave.

JUN 14 1927 HAMPTON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 23093

CERTIFICATE OF DEATH

E 23093

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Klasmeier

(a) RESIDENCE NO. 1100 Ridgely St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	64	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Henry Klasmeier

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hartman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Hagerstown

15 Filed JUN 14 1927 HAMILTON JONES, M. D. Registrar

By R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to June 12, 1927, that I last saw h[im] alive on June 12, 1927, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of leg (rt.)

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Pneumonia 14 days

Broncho Pneumonia (doration) yrs. mos 1 ds.

18 Where was disease contracted ? Home

If not at place of death?

Did an operation precede death? yes Date of May 27, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Simmons M. D.

(Address) Hagerstown

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross, Bklyn	June 15 1927

20 UNDERTAKER J. M. Cook ADDRESS 527 E Madison

OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state CAUSE very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23094
1-PLACE OF DEATH

90

E 23094
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 23rd. St. between Oak & Maryland Ave. Ward 12-51)

2-FULL NAME Joseph Overley.(C)

(a) RESIDENCE NO. 215 N. Ware St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced, HUSBAND of (XXXXXXXXX) Roxie Overley.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	46	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod carrier.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Randolph Overley.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah-------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Roxie Overley.(C)wife.

(Address) 2210 May St.

15 Filed JUN 14 1927, 19

C. HAMPSON JONES, M. D.

Per ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

6/13 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial June 14 1927

20 UNDERTAKER Virginia A. Booker ADDRESS 1463 N. Carey

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 23095
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 23095
REGISTERED NO.

City of BALTIMORE: (No. 1235 Myrtle Ave St. 7-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Johnson

(a) RESIDENCE NO. 1235 Myrtle Ave St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie R. Johnson

6 DATE OF BIRTH (month, day, and year) about 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md. June 11

PARENTS

10 NAME OF FATHER Geo. W. Johnson
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.
12 MAIDEN NAME OF MOTHER Julia Brown
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Annie R. Johnson
(Address) 1235 Myrtle Ave.

15 Filed JUN 14 1927 19 ..... Registrar R K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)
1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 6/14 19 27

20 UNDERTAKER Emmett Hensley ADDRESS McCulloh

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HAYWARD

101-001

E 23096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23096

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 782 Bradley Av St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Hayward

(a) RESIDENCE NO. 782 Bradley Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) about 1887

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Robert Hayward

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Garnett Hayward

(Address) 763 Vine St

15 Filed JUN 14 1927 19 C. HAMDEN JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

June 14 1927 (Address) 502 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ft. Auburn Cem June 14 27

20 UNDERTAKER ADDRESS

Simmons Beasley & Beddie 578

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23097

CERTIFICATE OF DEATH

E 23097

1-PLACE OF DEATH

REGISTERED NO. 74-001

City of BALTIMORE: (No. 11 S Second St. Burdly Ward 25 75)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Murr

(a) RESIDENCE NO. 11 S Second St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emelia Murr

6 DATE OF BIRTH (month, day, and year) May 15 1866

7 AGE Years 61 Months 7 Days 10 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Ashby Woods

(Address) 11 S Second St

Filed JUN 14 1927 C. HAMPSON JONES, M. D.

Per R.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

I HEREBY CERTIFY, That I attended deceased from Jan —, 1927, to June 11, 1927.

that I last saw h alive on June 10, 1927.

and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH was as follows:

Apoplexy —

(duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooke M. D.

, 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial June 14 1927

20 UNDERTAKER Margaret E Flynn — ADDRESS 1422 Light St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23098

E 23098

CERTIFICATE OF DEATH.

1850

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St 23-32 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Weber

(a) RESIDENCE NO. 1630 S. Charles St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	sungle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
✓		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Charles D. Weber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Atha Abbott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Atha A. Weber

(Address) 1630 S. Charles St

15 Filed ..... 19 ..... Registrar

NOV 14 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture d Skull-Her mother accidentally fell down stairs with her in her arms. at 508 N. Castle St.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Case M. D.

(Coroner)

6/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Pauls Island Md	6/17 1927
20 UNDERTAKER	**ADDRESS**
Joseph Givens	221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 23099

BOERNER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23099

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hosp. 1835 15-65 REGISTERED NO.

City of BALTIMORE: (No. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman F Boerner

(a) RESIDENCE NO. 4014 Bateman Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 31 1866

7 AGE: Years 61 Months 4 Days 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer): 079

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Gollet Boerner

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothy Strubat

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant

(Address): Hospital Records

15 Filed 6 14 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 13, 1927, that I last saw h[illegible] alive on June 13, 1927, and that death occurred, on the date stated above, at 2:55 A m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus - Cancer of Colon

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-10-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

Date of Burial: 6/15/1927

20 UNDERTAKER: Gr. Weber & Son

ADDRESS: 2503 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23100

E 23100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 5143 Park Heights Ave. St. 7-56 Ward)

2-FULL NAME George Engel

(a) RESIDENCE NO. 5143 Park Heights St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Amilia Engel

6 DATE OF BIRTH (month, day, and year): June 12 1849

7 AGE: Years 78 Months 0 Days 6

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 044

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Laurents Engel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Minie Willand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Howard J. Engel

(Address) 107 Fourth Ave

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

JUN 14 1927

Per ..... M.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan'y, 1926, to June 12, 1927.

that I last saw h[illegible] alive on June 11th 1927

and that death occurred, on the date stated above, at 12.45 Noon.

The CAUSE OF DEATH* was as follows:

Carcinoma bladder

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Ex Prostate

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted: —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscope

(Signed) Hamilton W. Eubert M. D.

June 13 1927 (Address) 1100 E. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

Date of Burial: 6/15/1927

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23101

CERTIFICATE OF DEATH.

90 E 23101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 W. North Ave St. 15-68 WARD)

2-FULL NAME James A Irwin

(a) RESIDENCE NO. 2131 W. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE 70 White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara M. Irwin

6 DATE OF BIRTH (month, day, and year) Jan. 16. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 24 Howard St.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Stobaeus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sara M. Irwin (Address) 2131 W. North Ave

15 Filed JUN 14 1927, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1925, to June 12, 1927, that I last saw him alive on June 11, 1927, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Heart Disease & Angina Pectoris

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? High blood pressure — mitral systolic murmur

(Signed) Jos. M. Langfitt, M. D.

June 13 1927 (Address) 1800 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 15 1927

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E Eager St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23102

CERTIFICATE OF DEATH.

90 E 23102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. North Point Rd. & Penna. R.R. St. 46-38 Ward)

2-FULL NAME Barbara Hellman

(a) RESIDENCE NO. North Point Rd. & Penna R.R. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Hellman

6 DATE OF BIRTH (month, day, and year) Aug 12/82

7 AGE: Years 74 | Months 10 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Conrad Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunde Gunda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Anna Sealach

(Address) rural Middleburgh

15 Filed JUN 4 1927 Registrar C. HAMPSON JONES, M. D.

Per K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12/27

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1925, to June 12 1927, that I last saw her alive on June 12 1927, and that death occurred, on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (If not at place of death)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Robt N. Athey, M. D.

June 13 1927 (Address) 1023 Fullerton Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial 6/15/27

20 UNDERTAKER: Philip Lenig — ADDRESS 206 Eden St.

Use ink in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Give cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Cavanna

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 23103

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 23103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) West Balt. Gen. Hosp ST. 6-10 WARD)

2-FULL NAME Mrs. Catherine Cavanna

(a) RESIDENCE NO. 130 No Madeira ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph L. Cavanna

6 DATE OF BIRTH (month, day, and year): Apr 18/1877

7 AGE: Years 50 | Months 1 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Rieck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Rieck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Wst Balt Gen. Hosp Reard

15 Filed , 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/5 1927, to 6/12 1927.

that I last saw her alive on 6/12 1927

and that death occurred, on the date stated above, at 12 35 A m.

The CAUSE OF DEATH* was as follows:

a Adenoma of Thyroid

(duration) 3 yrs. mos ds.

Chronic Nephritis 1 yr

CONTRIBUTORY (Secondary) Lobar Pneumonia yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/25/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Lobar

(Signed) Arthur L. Jensen M. D.

6/12, 1927 (Address) West Balt Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 6/15 1927

20 UNDERTAKER: Philip Henry

ADDRESS 2046 Eden St

C. HARRISON JONES, M. D.

JUN 14 1927

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 23104

1-PLACE OF DEATH 1 28194

REGISTERED NO.

City of BALTIMORE: (No. 4210 Evergreen Ave St. 28-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen V. Davis

(a) RESIDENCE NO. 4210 Evergreen Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Helen C. Davis

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1895

7 AGE Years 31 Months 7 Days 16 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Burrows

(c) Name of employer Adding Machine Co

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph J. Davis

11 BIRTHPLACE OF FATHER (City or town) Balto. Co.

(State or country) Md

12 MAIDEN NAME OF MOTHER Florence Chenowith

13 BIRTHPLACE OF MOTHER (City or town) Balto. Co.

(State or country) Md.

14 Informant Mrs. Helen C. Davis

(Address) 4210 Evergreen Ave

15 Filed JUN 14 1927, 19 C. HAMPSON JONES, M. D.

Per R.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to June 13, 1927, that I last saw ~~him~~ her alive on June 13, 1927, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Balto

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy Clinical

(Signed) C. C. Lynch, M. D.

June 13 1927 (Address) 4109 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reid Ridge Cem

Date of Burial June 15 1927

20 UNDERTAKER Robert L. Little

ADDRESS Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23105

E 23105

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 136 S. Ellwood Ave St. 1-V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia J. Chesney

(a) RESIDENCE NO. 136 S. Ellwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert W. Chesney

6 DATE OF BIRTH (month, day, and year): Jan. 8, 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	5	7	4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Wales

PARENTS

10 NAME OF FATHER: Thomas Lloyd

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Wales

12 MAIDEN NAME OF MOTHER: Jane Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Wales

14 Informant: Robert W. Chesney

(Address): 136 S. Ellwood Ave

15 Filed JUN 14 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9. 1927, to June 12 1927, that I last saw her alive on June 12 1927, and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clues

(Signed) H. Knox Sanders M. D.

June 14 1927 (Address) 2438 E 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: June 15 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Be sure to fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23106

CERTIFICATE OF DEATH

123 E 23106

1-PLACE OF DEATH Mercy Hospital — REGISTERED NO.

City of BALTIMORE: (No. ____ St. | - | Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Mason

(a) RESIDENCE NO. 743 S. Curley St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Mason

6 DATE OF BIRTH (month, day, and year): Dec 7, 1872

7 AGE — Years: 54 — Months: 6 — Days: 5 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Musch

11 BIRTHPLACE OF FATHER (City or town): ____

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliza J. Weller

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Mrs E. C. Stafford

(Address): 743 S. Curley St

15 Filed ____, 19 ____ HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 12, 1927, that I last saw h[er] alive on June 12, 1927, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows: Cholecystitis & Lithiasis

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/7/27

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Examination

(Signed) J. Wolfe, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — Date of Burial: June 15 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23107 × 199 E 23107

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward

2-FULL NAME George Clarich

(a) RESIDENCE NO. Deep Creek ave,, Essex St. Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. (ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) April 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work "Liquor Dealer"

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER Matthew Clarich

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Anthony Clarich

(Address) 701 S. Bond St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D.

By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage-struck with mallet in a fight. Homicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. [illegible] Coroner, M. D.

(Coroner)

6/14/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Oak Lawn Cemetery — Date of Burial June 15 19 27

20 UNDERTAKER — Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23108 *185 E 23108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore Hospital REGISTERED NO.

City of BALTIMORE: (No. 1313 S Light St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick White

(a) RESIDENCE NO. Pasadena, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 - 1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Pa

PARENTS

10 NAME OF FATHER Fred White

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hospital Record

(Address)

15 6-4-1927 C. HAMPSON JONES, M. D.

Per Roll Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6/13/27

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to June 13, 1927, that I last saw h.. alive on June 12, 1927, and that death occurred, on the date stated above, at 1:35 m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculan

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fall

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy? No

What test confirmed diagnosis!

(Signed) H. E. Miller, M. D.

, 19 (Address) South Balto Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pasadena A.A. Co Md Date of Burial June 14 1927

20 UNDERTAKER Robert E. Williams ADDRESS 1515 McCulloh St

Be sure to print plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23109

CERTIFICATE OF DEATH

46

E 23109

1-PLACE OF DEATH Md. General Hospital REGISTERED NO.

City of BALTIMORE: (No. 21-29 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Riley

(a) RESIDENCE NO. 516 Guilford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	47	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Walter Hall

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Gunn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant

(Address)

15 Filed JUN 14 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 12, 1927, that I last saw h[illegible] alive on June 12, 1927, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6-6-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemy Date of Burial June 15 '27

20 UNDERTAKER F. A. Wauser & Son ADDRESS 703 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23110

CERTIFICATE OF DEATH.

90

E 23110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 338 E. Federal ST. 12-14 WARD)

2-FULL NAME Abdiel B. Wherley

(a) RESIDENCE NO. 338 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lyrilla E. Wherley

6 DATE OF BIRTH (month, day, and year) January 22, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R.R Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) N?

(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Solomon Wherley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Sarah Bortner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Samuel C. Wherley

(Address) 413 E. Lanvale St.

15 Filed JUN 4 1927, 19 C. HAMPSON JONES, M. D. Registrar

By RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to June 14, 1927, that I last saw him alive on June 14, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Aortic sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) W. W. Peace, M. D.

6-14, 1927 (Address) Preston & St Paul Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fissel's, York Co., Pa.

DATE OF BURIAL June 17, 1927

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 1256 Madison Ave

HON is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23111

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 23111

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md St. 26-37 Ward)

2-FULL NAME Ida Hunt

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Hunt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Unknown

14 Informant Balto City Hospls

(Address) Balto Md

Filed 6 1927 19 4448

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6-10 '27

17 I HEREBY CERTIFY, That I attended deceased from 3-26- 1927 to 6-10- 1927,

that I last saw her alive on 6-10- 1927

and that death occurred, on the date stated above, at 10.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Pulmonary Tbc.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary Ida Hunt M. D.

6/11, 19 27 Address 1 Bottum Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Or the same in plain terms, so that it may be properly classified. Exact statement of the name of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23112

CERTIFICATE OF DEATH.

90 E 23112

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ford

(a) RESIDENCE NO. 1002 S. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) District Columbia

PARENTS

10 NAME OF FATHER Richard Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Margaret -?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant (Address) Records

15 Filed ..... 19 1449 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1927

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to June 10, 1927, that I last saw h.. alive on June 9, 1927, and that death occurred, on the date stated above, at 5.45 A.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Myocardial hypertrophy and
Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Lemmon, M. D.

June 1 1927 BALTIMORE CITY HOSPITALS

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

BALTIMORE CITY HOSPITALS
UNIVERSITY OF MARYLAND
C. HAMPSON JONES, M. D.
JUN 14 1927

JUN 14 1927

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23113

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 129 E 23113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles White

(a) RESIDENCE NO. Windsor, Canada St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Windsor

(State or country) Canada

PARENTS

10 NAME OF FATHER Wm White

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Susan —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 BALTIMORE CITY HOSPITALS

Informant Records

(Address) [redacted]

15 Filed June 14 1927 C. HAMPSON JONES, M. D. Registrar

Per 1460 KPP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17

I HEREBY CERTIFY, That I attended deceased from May 11, 1927, to June 13, 1927, that I last saw him alive on June 12, 1927, and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & Laboratory

(Signed) C. Hampson Jones M. D.

June 14 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Please answer all questions in full, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23114

CERTIFICATE OF DEATH

31 E 23114

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (1-24) St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Beatty

(a) RESIDENCE NO. 831 Druid Hill ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Isaac Beatty

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Fannie Devaune

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

1454 CHJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to June 10, 1927.

that I last saw him alive on June 10, 1927.

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Stallings M. D.

6-10-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

JUN 14 1927

Department of Health

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23115

E 23115

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE, JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

2-FULL NAME Baby Flavas

(a) RESIDENCE NO. 961 Chapel St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28, 1927

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Buster Scott

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) ?

12 MAIDEN NAME OF MOTHER Francis Davis

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country) JOHNS HOPKINS HOSPITAL

14 Informant Records

(Address)

15 Filed ....., 19 ..... 1458 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from May 28 1927, to June 11, 1927, that I last saw h.. alive on June 11, 1927, and that death occurred, on the date stated above, at 8 00 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Birth injury

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? ..... Report not obtained

What test confirmed diagnosis? .....

(Signed) H. E. Hamilton, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23116

CERTIFICATE OF DEATH.

38 E 23116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 N. MOnroe St. ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Thomas

(a) RESIDENCE NO. 1720 N. Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late William H. Thomas

6 DATE OF BIRTH (month, day, and year) May 8, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	I	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER -------- Gould

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Corinne Day
(Address) 1720 N. Monroe St

15 Filed 6-14 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9th, 1927, to June 13, 1927, that I last saw h[e]r alive on June 13, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Endocarditis (Luetic) Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Cystitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1720 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL June 15 1927

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St.

HEALTH IS VERY IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

(Howeth)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23117

CERTIFICATE OF DEATH

90 E 23117

REGISTERED NO.

1-PLACE OF DEATH Southern Hospital

City of BALTIMORE: (No. ~~2510~~ 2510 Greenmount St. 50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bauelto

(a) RESIDENCE NO. 2510 Greenmount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/2/61

7 AGE: Years 66 | Months 1 | Days 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Wm Howeth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Victor Thompson

(Address) 219 Pennsylvania Ave

15 Filed ....., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest and autopsy I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) a.

(duration) .....yrs. .....mos. .....ds.

(Signed) John H. Norman M. D.

(Coroner)

6/13, 1927 (Address) 2632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md Date of Burial: June 15 1927

20 UNDERTAKER: Harry A. Nitzle ADDRESS: 1531 W. Lombard

C. HAMPSON JONES, M. D.

1927

APR 13

Be certain to write plainly in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 23118

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23118

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1328 N. Fremont Ave ST., 15-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Carberry

(a) RESIDENCE NO. 1328 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria

6 DATE OF BIRTH (month, day, and year): Aug 31 — 1885

7 AGE: Years 41 Months 9 Days 10 12 11 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Eateries

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Carberry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Amada Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Maria Carberry (Address): 1328 Fremont Ave

15 Filed: June 14 1927 By: G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to June 12, 1927, that I last saw h[illegible] alive on June 11, 1927 and that death occurred, on the date stated above, at 8 Hrs m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Ex Laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Claybrook M. D.

June 13 1927 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 6/15 1927

20 UNDERTAKER: Wm. Geo. C. Holland — ADDRESS: 1631 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23119

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

E 23119

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 Maryland Ave. St.) (Ward) 20

2-FULL NAME Irma Clayton

(a) RESIDENCE NO. 2019 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25-20

7 AGE — Years: 6 — Months: 7 — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Thier Clayton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Gibson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Elanora Limberg

(Address) 511 Myrtle St

15 Filed JUN 15 1927, 19 Per K.F. Registrar

C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull with Fracture of 5th & 6th ribs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

June 15, 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 6/16/1927

20 UNDERTAKER: Mrs. Geo. E. Holland — ADDRESS 1651 Druid Hill Ave

Instructions: Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-003

E 23120

CERTIFICATE OF DEATH

E 23120

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

City of BALTIMORE: (No. St. 15 Ward) 61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mollie C. Mitchell

(a) RESIDENCE NO. 3107 Westwood Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Warren M Mitchell

6 DATE OF BIRTH (month, day, and year) Feb 3 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	47	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER JERE Jerry L Boyd

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Betts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Norfolk Va.

14 Informant Hospital records

(Address)

15 Filed JUN 15 1927 19

G. HAMPSON JONES, M. D. Registrar

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 19 27

17 I HEREBY CERTIFY, That I attended deceased from 5/20/27, 19..., to June 12, 19 27, that I last saw h 9 alive on June 12, 19 27, and that death occurred, on the date stated above, at 2:20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) Nat known yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy and Acute Auricular Fibrillation

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

Date of Burial June 15 1927

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St.

Do not abbreviate or use ditto marks. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 23121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 E 23121

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No St. Elizabeths' Home ST 9-47 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Isaac Wells

(Residence in Baltimore: No. St. Elizabeths' Home - Chesnut Hill Ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE negro | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH November (Month) 27 (Day), 1926 (Year)

7 AGE 6 yrs. 7 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Wells

11 BIRTHPLACE OF FATHER (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Henrietta Lowery

13 BIRTHPLACE OF MOTHER (State or country) S. Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henrietta H. Wells

(Address) 743 Eastern Ave

15 Filed JUN 15 1927, 191 HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 13 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to June 13 1927.
that I saw h alive on June 13, 1927.
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1 mos. ds

Contributory (SECONDARY) Bronchio Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) Frank J. Ayd M. D.

June 14, 1927 (Address) 2025 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 15, 1927

20 UNDERTAKER Howard Easton ADDRESS 916 Eutaw

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Glasser 100-601

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 23122 — PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C E 23122

CITY OF BALTIMORE (No. 3108 Oakfield Ave St. 15-65 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME wm Glasser

(Residence in Baltimore: No. 3108 Oakfield ave St.; 14 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: W.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: May-18- (Month) (Day), 1825 (Year)

7-AGE: 42 yrs. mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Solomon Glasser

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Esther Glasser

(Address) 3108 Oakfield ave

Filed JUN 15 1927 19 Per C. HAMPTON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) - 14 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April-14, 1927, to June-14 1927, that I saw him alive on June-14- 1927, and that death occurred, on the date stated above, at 7.30 a. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 11 ds

Contributory (SECONDARY) Myocardial Insufficiency

(Duration) yrs. One mos. 14 ds.

(Signed) Herman Seidel M. D.

June-14, 1927 (Address) Herman Seidel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3108 Oakfield ave

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rodeph Shalom — DATE OF BURIAL: June 15 1927

20-UNDERTAKER: Sol Kramer & Bro — ADDRESS 112 E Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 23123

REGISTERED NO. E 23123

1-PLACE OF DEATH

City of BALTIMORE: (No. 139 W Hamburg St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Spriggs

(a) RESIDENCE NO. 139 W Hamburg St. 23 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 6 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 7 1926

7 AGE — Years: 10 Months: — Days: 5

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Walter Spriggs

11 BIRTHPLACE OF FATHER (City or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Walter B. Spriggs

(Address): 139 W. Hamburg St.

15 Filed JUN 15 1927 C. HAMILTON JONES, M. D. Registrar

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/12/1927

17 I HEREBY CERTIFY, That I attended deceased from 6/10/1927, to 6/13/1927, that I last saw her alive on 6/12/1927, and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Acute (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Recurrent Bronchitis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) O. Dan Bowles, M. D.

6/13/1927 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int Auburn Cem. Date of Burial 6-15 1927

20 UNDERTAKER: George T. A. Gitt[illegible] ADDRESS 1735 Druid Hill Ave.

DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23124 E 23124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3230 Barclay St. 12-50 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Wright

(a) Residence No. 3230 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Alfred Wright

6-DATE OF BIRTH (month, day and year) 1867

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Alfred Wright

(Address) 3230 Barclay St.

15- Filed, 192 Registrar.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12, 1927

17- I HEREBY CERTIFY, That I attended deceased from Apr. 22, 1927, to June 11, 1927, that I last saw her alive on June 11, 1927, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Microscopic

(Signed) P. Gardner Mitchell M. D.

June 14, 1927 (Address) 1534 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem	June 15, 1927
20-UNDERTAKER	ADDRESS
Jas J. G. Locke	1302 Jefferson

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23125

REGISTERED NO. E 23125

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 23125 DEATH

CITY OF BALTIMORE: (No. 2100 E. Baltimore St WARD 10)

2-FULL NAME Joseph M. Offel

(a) RESIDENCE NO. 134 N. Luzerne ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Offel

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Offel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lintzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from August, 1925, to June 14, 1927.

that I last saw h alive on June 14, 1927.

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Schaffner, M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rebecca Rosedale DATE OF BURIAL 6/15 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23126 — 1-PLACE OF DEATH

170 E 23126 — REGISTERED NO.

City of BALTIMORE: (No. John Hopkins Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reba Rosen

(a) RESIDENCE NO. 22 N. Montford Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) UNKNOWN

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Rosen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Mindel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Authur August

(Address) 22 N. Montford Ave.

15 FILED JUN 15 1927 — 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 14 - 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in abdomen

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mental Depression

(duration) yrs. mos. ds.

(Signed) J. S. Collins M. D.
(Coroner)

6/15/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rossdale — Date of Burial 6-15-1927

20 UNDERTAKER Jack Levin — ADDRESS 1139 E. Balto. St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23127

CERTIFICATE OF DEATH.

x 199 E 23127

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

2-FULL NAME Mrs Susan Saffer

(a) RESIDENCE NO. Phila. Rd & Thomas Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Saffer

6 DATE OF BIRTH (month, day, and year) Dec 21/1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
25	26	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hous wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Benj. E. Ellis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Anna Burger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant John M. Saffer

(Address) Phila Rd & Thomas Ave

15 Filed 5 1927 C. HARRISON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Infected Abortion

Self induced

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Walker M. D.

(Coroner)

6/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 6/15 1927

20 UNDERTAKER Philip Lewig ADDRESS 30 6 Calhoun

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23128

CERTIFICATE OF DEATH.

E 23128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 5109 Center Av. ST. (or WARD) Gorsuch

2-FULL NAME Henry Foreman Holmes.

(a) RESIDENCE NO. 5109 Center Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nancy Bevan Holmes

6 DATE OF BIRTH (month, day, and year): Oct 4, 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Underwriter

(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

(c) Name of employer: U.S.F.&G. Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Thos. H Holmes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Katherine Mc Donald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore.

14 Informant: David H. Andrew.
(Address): 3044 Guilford Av.

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar
Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to June 14, 1927.

That I last saw h in alive on June 14. 4 AM, 1927.

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows: Cancer

Cancer 2 (Round cell carcinoma) abdomen —

(duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Intention

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination of tissue

(Signed) Henry Lyman Mettle, M. D.

June 15, 1927 (Address) 1229 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 17 1927

UNDERTAKER: John B. Spence

ADDRESS: 1325 N. Caroline St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23129

CERTIFICATE OF DEATH.

90 E 23129

REGISTERED NO.

1-PLACE OF DEATH 935 Rutland Ave 13

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Myers

(a) RESIDENCE No. 935 Rutland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred cont yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-3- 1927 to 6-12 1927

that I last saw her alive on 6-12 1927

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Arteriosclerosis
Hemiplegia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

1927 (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address): Mary Brown 935 Rutland Ave

15 Filed JUN 5 1927, 19 Per C. HAMPTON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn cemetery

DATE OF BURIAL: June 15 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Walbrook

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23130

CERTIFICATE OF DEATH

E 23130

1-PLACE OF DEATH St Josephs Hospital

City of BALTIMORE: (No. Caroline & Oliver Sts. 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Ulrich (Agnes Ludwig)

(a) RESIDENCE NO. St Josephs Hospital St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Sister

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 64 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Adam Ludwig

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Cathrine Bissel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Sister Mary Ulrich

(Address)

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 19 27, to June 14, 19 27,

that I last saw her alive on June 14, 19 27,

and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted at home.

If not at place of death? —

Did an operation precede death? No Data of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical.

(Signed) H R McCarroll M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: June 17 19 27

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23131

E 23131

CERTIFICATE OF DEATH.

25-32 90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1018 First St., Westport WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hiltner

(a) RESIDENCE No. 1018 First St., Westport ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Hiltner

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steam-Fitter 060

(b) General nature of industry, business, or establishment in which employed (or employer): Retired abount

(c) Name of employer: 2 years

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER John Hiltmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Mary Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Mrs. Annie Markins.
(Address) 1018 First St., Westport

15 Filed JUN 15 1927 — C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to June 13-, 1927, that I last saw h alive on June 12-, 1927, and that death occurred, on the date stated above, at 5. 20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hypertension

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Chas A Cahn M. D.

6/13 1927 (Address) 2105 W Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: June 16 1927

20 UNDERTAKER: Nelson E. Stiles — ADDRESS: 231 Md. Ave. Westport.

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23132

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23132

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1136 Scott St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginia Jones

(a) RESIDENCE NO. 1136 Scott Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Jones

6 DATE OF BIRTH (month, day, and year) August 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	68	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimcre,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob S. Eyerly

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary E. Bolin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Mrs. Bird V. Zeitler

(Address) 1136 Scott Street

15 Filed ....., 19 .....

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1926, to June 13, 1927, that I last saw her alive on June 13, 1927, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J M Dennett, M. D.

6/15, 1927 (Address) 62 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	6/16/27 19

20 UNDERTAKER Jos. Block

ADDRESS 1004 W. Baltimore St.

JUN 15 1927 C. HARRY W. JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—9-30—A. & Co.—250 Bks.

E-23133

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3506 Forest Park Avenue ST. 15 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Richard Holljes

(a) RESIDENCE NO. 3506 Forest Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helen D. Holljes

6 DATE OF BIRTH (month, day, and year) 8-8-91

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mch. Engineer
(b) General nature of Industry, business, or establishment in which employed (or employer) B & O R R
(c) Name of employer B & O R R Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Diedrich Holljes
11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark
12 MAIDEN NAME OF MOTHER Von Baltmann
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Helen D Holljes
(Address) Paterson Court Apts

15 Filed June 15, 27, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1927

17
I HEREBY CERTIFY, That I attended deceased from ..., 19 18, to ..., 19 27
that I last saw h in alive on 14th June 1927, 19
and that death occurred, on the date stated above, at 9.30 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.
CONTRIBUTORY Cardiac Dilatation
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? France
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs and Symptoms
(Signed) Wm A. Duvall M. D.
, 19 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park — DATE OF BURIAL 6-16-27, 19

20 UNDERTAKER Jos Cook. Baltimore, — ADDRESS Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

143-002

E 23134

CERTIFICATE OF DEATH.

24-33

E 23134

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. So. Balto. Gen. Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS. MAUDE PORTER

(a) RESIDENCE NO. 1255 Riverside Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 Color or Race: WHITE

5 Single, Married, Widowed, or Divorced, (write the word): MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lee Porter

6 DATE OF BIRTH (month, day, and year): Sept 14/1899

7 AGE: Years 27 | Months 9 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Broomes Island Md

PARENTS

10 NAME OF FATHER: Benjamin Rogers

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Wilhemine Bowen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Calvert Co Md

14 Informant: Mr James S Rogers

(Address): Broomes Island md

15 Filed ..... 19 ..... Registrar

NOV 5 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

JUNE 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from JUNE 12, 1927 to JUNE 15, 1927

that I last saw her alive on JUNE 15, 1927,

and that death occurred, on the date stated above, at 145 A. m.

The CAUSE OF DEATH* was as follows:

LEFT TUBAL PREGNANCY

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) INTRA ABDOMINAL HEMORRHAGE

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? NO Date of ——

Was there an autopsy? YES

What test confirmed diagnosis? AUTOPSY

(Signed) James E Steppman, M. D.

6/15, 1927 (Address) 1228 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvert Co Md — Date of Burial: Parkers Wharf. June 15 1927

20 UNDERTAKER Calvert Co Md — ADDRESS: John F Denny — 715 Light St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

CHARLES E. THOMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23135
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. H-30 WARD)

REGISTERED NO. E 23135
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Hardy

(a) RESIDENCE NO. Pikesville md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: ~~Cook~~ Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Nurse 021
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Danville Va

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Iola M. Smith
(Address) 106 N. Eddison St.

15 Filed JUN 15 1927 19 Registrar R.J.C.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to June 11, 1927,
that I last saw h[illegible] alive on June 11, 1927,
and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Arteriosclerosis
Chr. Interstitial Nephritis
(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Intracranial Hemorrhage.
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy? No..
What test confirmed diagnosis?

(Signed) E K Mulber M. D.
, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL June 15 1927

20 UNDERTAKER: Lemuel Tinsley ADDRESS 5[illegible] W. Saratoga

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 23136

E 23136

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2119 E Eager St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Hauck

(a) RESIDENCE NO. 2119 E Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21-1926

7 AGE Years 9 Months Days 23 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Samuel P. Hauck

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Hilda Deacon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Mr Samuel P. Hauck

(Address) 2119 E Eager St

15 Filed JUN 13 1927, 19 C. HERBERT JONES, M. D. Registrar

Per KH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14- 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to June 14 1927,

that I last saw h alive on June 14 1927,

and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

Date of Burial June 16 1927

20 UNDERTAKER John Meiers

ADDRESS 200 S Broadway

IMPORTANT: Should Sole CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

203 E 30 E 23137

CERTIFICATE OF DEATH.

41 E 23137

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Urban

(a) RESIDENCE NO. 1906 E Biddle St St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-7-27

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	5 weeks	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Urban

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Md

12 MAIDEN NAME OF MOTHER Genevieve Dugent

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Md

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL, M. D.

15 Filed JUN 15 1927, 19 C. HAMPSON JONES, M. D.

Per ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to June 14, 1927, that I last saw h.. alive on ____, 19 ____, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) ____ yrs. 1/2 mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? Yes. What test confirmed diagnosis? Blood culture

(Signed) H. E. Pothman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — Date of Burial June 16 27

20 UNDERTAKER John Leerier — ADDRESS 2008 Orleans

very important. See instructions on back of certificates.

Exact statement of OCCUPATION is

Spec.—12 9-25—A Co.—200 Bks.

2 E 23138

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 23138

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE JOHNS HOPKINS HOSPITAL St. 28-63 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Haynie

(a) RESIDENCE NO. 4106 Holbrook Ave St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-9-1913

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Randolph Haynie

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Alice Leach

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records — JOHNS HOPKINS HOSPITAL

(Address)

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

JUN 5 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8 1927, to June 13, 1927, that I last saw h[illegible] alive on June 13, 1927, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Brain Tumor, glioma (temporal)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5 25 27

Was there an autopsy? yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Geo. G. Young M. D.

June 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial June 16 1927

20 UNDERTAKER Wm Fuchsen Sons ADDRESS Norristown Pa

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23139

CERTIFICATE OF DEATH.

66 E 23139

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 N. Chapel St St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley Smith

(a) RESIDENCE NO. 605 N. Chapel St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Northeastern Police Dept

(Address)

15 Filed ... 19 ...

Per ... Registrar

1460

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 10-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) J. S. Hoage, M. D.

(Coroner)

6/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

C. HAMPSON JONES, M. D.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23140

CERTIFICATE OF DEATH.

188-002

E 23140

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 76-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Daley

(a) RESIDENCE NO. Balto. City Hospital St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXX

6 DATE OF BIRTH (month, day, and year): XXXX

7 AGE: Years: 56 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Probably Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) "

14 Informant: Eastern Dist Police

(Address)

15 Filed 19 (G. HAMILTON JONES, M. D.)

4461 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally struck by St. car (200 block 15th St.) Frac Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Pace, M. D.

(Coroner)

6/15/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23141

CERTIFICATE OF DEATH.

74-001

E 23141

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 203 N. Arlington Ave (St.) (Ward) 26

2-FULL NAME Eliza Wright

(a) RESIDENCE NO. 203 N. Arlington Ave (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col'd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Henry Ball

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Juliet Middleton

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Catherine Carroll

(Address) 203 N. Arlington Ave

15 Filed _____ C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 11 hours

CONTRIBUTORY (Secondary) Rheumatism

(duration) ..... yrs. ..... mos. ..... ds.

Jun 13 1927 (Signed) Thos. B. Horton M. D. (Coroner)

(Address) Curtis Bay, Balto. Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER

ADDRESS

JUN 15 1927

Department of Health

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23142

E 23142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md. 27-46 129

CITY OF BALTIMORE: (No. 623 McCabe Ave ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Maginnis

(a) RESIDENCE NO. 623 McCabe ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): Aug. 19, 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~41~~	41	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: David Ebsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Georgianna Crispt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Mabel Ebsworth

(Address) 1210 Bond St.

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per RRW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 13, 1927,

that I last saw her alive on June 13, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Acute Dilatation of Heart

CONTRIBUTORY (Secondary) { (duration) Chronic Interstitial Nephritis yrs. mos. ds.
Chronic Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests.

(Signed) H C Hess, M. D.

, 19 (Address) 5200 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 16, 1927

20 UNDERTAKER: H. Cook — ADDRESS: 602 E North Ave

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23143 E 23143

CERTIFICATE OF DEATH

118-002

11-24

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emily H. Griffith.

(a) RESIDENCE NO. 341 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13. 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Dr. Wm. Griffith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Whitely

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Charles Baker

(Address) Baltimore Md

15 Filed 6 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to June 15, 1927, that I last saw h alive on June 15, 1927, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of June 7. 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Raymond F. Johnston, M. D.

6/15. 1927 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: June 17 1927

20 UNDERTAKER: Henry Meakins & Co

ADDRESS: Cathedral & Franklin

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23144

CERTIFICATE OF DEATH

129 E 23144

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Deaver

(a) RESIDENCE NO. 2321 Mc Elderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Deaver

6 DATE OF BIRTH (month, day, and year): Nov. 3- 1865

7 AGE: 71 Years 7 Months 10 Days — 72 6

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Camden.

(State or country): N. J.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): unknown

12 MAIDEN NAME OF MOTHER: Hester Erby

13 BIRTHPLACE OF MOTHER (city or town): Camden

(State or country): Co N. J.

14 Informant: Records

(Address): BALTIMORE CITY HOSPITALS

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 13, 1927.

that I last saw h[illegible] alive on June 13, 1927.

and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and Insufficiency

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & Laboratory

(Signed) R Hoopes Smith M. D.

June 14 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from [redacted] Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: 6/16 1927

20 UNDERTAKER: Robert Brookes Son

ADDRESS: Cor Calhoun Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23145

CERTIFICATE OF DEATH.

155E 23145

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital Sch'l St.; 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Goetz

(Residence in Baltimore: No. 607 N. Kenwood Ave. City St.; 7 yrs. 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July (Month) 10th (Day), 1919 (Year)

7-AGE. 7 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Clarence Piersol Goetz

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Marie Anna Hagengast

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. K. Gundalfinger M.D.

(Address) Children's Hosp. School

15-

Filed ..... 1927 C. HAMPSON JONES, M. D. Registrar.

Per Rcrk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 15th (Day), 1927 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1927, to June 15th 1927, that I saw her alive on June 15th 1927, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis - Tuberculosis of Lungs, Heart, Brain, Bone, Joint & Glands

Treated 4 months at Children's Hosp. School (Duration) 1 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Hemoptysis & Exsanguination

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Robt. K. Gundalfinger M. D.

June 15, 1927 (Address) Children's Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. 30 ds. In the State 7 yrs. 11 mos. 5 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood Cem	June 17, 1927
20-UNDERTAKER	ADDRESS
Wendell Dilgard Son	57 S. Howard

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23146

CERTIFICATE OF DEATH.

31

REGISTERED No. E 23146

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 4-26

City of BALTIMORE: (No. _____ St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Brown

(a) RESIDENCE NO. 306 N. Pine St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Hollins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Futtle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed JUN 1927 C. HAMPSON JONES, M. D. Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to June 13, 1927, that I last saw h[redacted] alive on June 12, 1927, and that death occurred, on the date stated above, at 4 1 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TBC.

(duration) ....yrs. 2 ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & laboratory

(Signed) R. Hooper Smith, M. D.

June 13 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease [redacted] from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial June 16 1927

20 UNDERTAKER Samuel Carter ADDRESS 916 Gay st

very important. See instructions on back of certificates. Exact statement of OCCUPA[redacted] may be properly classified.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23147

CERTIFICATE OF DEATH.

113

E 23147

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 334 Potapsco Ave St. 16-36 Ward)

2-FULL NAME Sidonia L. Havlicek

(a) RESIDENCE NO. 334 Potapsco Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 18 Dec 1926

7 AGE — Years: | Months: 5 | Days: 27 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country)

PARENTS

10 NAME OF FATHER: John Havlicek

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Czechoslavakya

12 MAIDEN NAME OF MOTHER: Mary Staula

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Czechoslavakia

14 Informant: John Havlicek
(Address): 334 Potapsco

15 Filed 6-15 1927 C. HAMPSON JONES, M. D. Registrar
Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 15, 1927, that I last saw h[illegible] alive on June 15, 1927, and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical

What test confirmed diagnosis? —

(Signed) A. W. Kerr, M. D.

6/15 1927 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — Date of Burial: June 16 1927

20 UNDERTAKER: Frank Crockett — ADDRESS: 1916 Eastern Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23148

CERTIFICATE OF DEATH.

129 E 23148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 6-9 Ward)

2-FULL NAME Jennie L. Mead (MEAD)

(a) RESIDENCE NO. Church Home & Infirmary Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: Rev. George W. Mead.

6 DATE OF BIRTH (month, day, and year): Sept. 28-1843

7 AGE: Years 83 | Months 8 | Days 17 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Litchfield

(State or country): Conn.

PARENTS

10 NAME OF FATHER: George W. Rockwood.

11 BIRTHPLACE OF FATHER (city or town): Bedford

(State or country): Mass.

12 MAIDEN NAME OF MOTHER: Jannie M. Woodruff.

13 BIRTHPLACE OF MOTHER (city or town): Bedford

(State or country): Pa

14 Informant: Justus Phelps Son

(Address): 1504 W. Fayette St.

15 Filed: JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15 1926, to June 15, 1927, that I last saw her alive on June 14, 1927, and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic interstitial. Arteriosclerosis, general. Chr. Valvular Ht. dis. (duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Merrigwell T. Shelton M. D.

June 15, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: June 16 1927

20 UNDERTAKER: Hughes & Lowe Inc — ADDRESS: 414 N. Broadway

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

(Frehish)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23149

CERTIFICATE OF DEATH

90 E 23149

REGISTERED NO.

1-PLACE OF DEATH 4303 Fernhill Ave.

City of BALTIMORE: (No. Regina Frehish St. 26-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 4303 Fernhill Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White Hebrew

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip Frehish

6 DATE OF BIRTH (month, day, and year): Apr 27/1833

7 AGE 93 Years 6 Months 17 Days 18

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 37

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Ephraim Shaus

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Sollie Frehish

(Address) 4303 Fernhill Ave

15 Filed JUN 15 1927, 19

Registrar RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6/14/27

17 I HEREBY CERTIFY, That I attended deceased from 6/8, 19 27, to 6/14, 19 27, that I last saw h.. alive on 6/13, 19 27, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endo-carditis

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) L. Richards M. D.

, 19 (Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Achen Gemiluth Chesed Cemetery — Date of Burial: June 16/ 1927

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 33 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23150

CERTIFICATE OF DEATH

90 E 23150

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 326-N. Eutaw St. 1-25 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Laing

(a) RESIDENCE NO. 326 N. Eutaw St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Laing

6 DATE OF BIRTH (month, day, and year) 12/26/1868

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	58	5	24 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath (State or country) Md.

PARENTS

10 NAME OF FATHER John Rowland

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nanie Laing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles Laing (Address) 326-N. Eutaw

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Tuesday June 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1927, to June 14th, 1927, that I last saw h[er] alive on June 12th, 1927, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows: Val. Dis. of Heart. (Endocar.)

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) Fractional yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Rob Tate, M. D.

, 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vernon Cemetery West Balto Pa. Date of Burial 6/17/27 19

20 UNDERTAKER George J. Reith ADDRESS 1735 Harford Ave

IF DEATH IS NOT properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23151

CERTIFICATE OF DEATH.

1927 E 23151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph T. Owens

(a) RESIDENCE NO. 1639 W. Brooks St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Owens

6 DATE OF BIRTH (month, day, and year) Aug 27-1889

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
✓	37	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Alexander Owens

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Clara Hayden

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Clara Owens

(Address) 653 W. Lafayette

15 Filed ..... 19..... Registrar

JUN 15 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Multiple Stab wound of Body

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) H. T. Hennessy M. D.

(Coroner)

June 15, 1927 (Address) 2802 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial June 19 1927

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1400 Mosher

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Saul.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23152

CERTIFICATE OF DEATH.

129

E 23152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1362 Fawson ST. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. Saul.

(a) RESIDENCE NO. 1362 Fawson ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schumms.

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	61	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. Do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Francis Advertising Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Saul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Saul

(Address) 1362 Fawson Av

15 Filed JUN 16 1927 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 14, 1927, that I last saw him alive on June 13, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Chronic Parenchymatous Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 7. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO. Date of

Was there an autopsy? NO

What test confirmed diagnosis? Hist + B.P. Chs

(Signed) Thos J. Stevens, M. D.

6-17-27 (Address) 2918 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL June 17, 1927

20 UNDERTAKER Chas R. Sherwood

ADDRESS 1501 Eutaw Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002

E 23153 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2125 Etting ST. (WARD) 14-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Smith

(a) RESIDENCE. No. 2125 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 13-1919

7 AGE: Years 7 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS:
10 NAME OF FATHER: Shakespeare Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ned
12 MAIDEN NAME OF MOTHER: Toleda Brown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ned

14 Informant: Toleda Brown
(Address) 2125 Etting St.

15 Filed . 19 . Registrar

JUN 15 1927 C. HAMPTON JONES, M. D. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12 1927 to June 14 1927
that I last saw h[illegible] alive on June 14 1927
and that death occurred on the date stated above, at 10:11 A.M.
The CAUSE OF DEATH* was as follows:
Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

19 (Address) 2037 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: June 16 1927

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 McCaren St

THIS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

NEEDER

HEALTH DEPARTMENT—CITY OF BALTIMORE

153

E 23154

E 23154

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Joseph Hospital St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Neider

(a) RESIDENCE NO. 2430 E. Monument St. 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S. if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late anna M. Neider

6 DATE OF BIRTH (month, day, and year): Sept. 2nd 1837

7 AGE: Years 90 Months 10 Days 13 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Basket Maker

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: John Needer

(Address): 2528 Fait ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 15 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 24 1927 to June 15 1927

that I last saw him alive on June 15 1927

and that death occurred, on the data stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Inguinal Abscess

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-28-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) W. Ward R. Miranda M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

Date of Burial: June 17 1927

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 4038 Wash Blvd

JUN 16 1927 C. H. D.

Rec

very important. See instructions on back of certificates.

...be properly classified. Exact statement of OCCUPATION is ...

Cor.—12-9-25—A Co.—200 Bks.

E 23155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 23155

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 S. Highland Ave St., 26-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Spiegel

(a) RESIDENCE NO. 27 S. Highland Ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Sept 29/1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	54	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER John Spiegel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Getty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Jacob Dotterrich

(Address) 27 S. Highland Ave

15 Filed JUN 16 1927 C. Hincey Jones, M. D. Registrar

Per JCH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/27 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. ds.

(Signed) J. H. Price M. D.

(Coroner)

6/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial June 17, 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23156 129 E 23156

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1030 Edmondson Ave St. 16-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Wise Harris

(a) RESIDENCE NO. 1030 Edmondson Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo E. Harris

6 DATE OF BIRTH (month, day, and year): Sept 19, 1852

7 AGE: Years 74 Months 9 Days 26 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: Sr. Powell

11 BIRTHPLACE OF FATHER (City or town): Wales

(State or country)

12 MAIDEN NAME OF MOTHER: Sallie Wise

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Mrs Lillian A. Saunders

(Address) 1232 Edmondson Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: June 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 19 27, to June 16th, 19 27, that I last saw h.. alive on June 15, 1927, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Oedema,

1 Hour (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and urinary analysis

(Signed) Charles Getz, M. D.

June 15. 1927 (Address) 1111 N. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial JUN 17 1927 19

20 UNDERTAKER: Geo W Little — ADDRESS

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23157 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 617 Edgewood St. 16-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James F. Bradburn,

(a) Residence No. 617 Edgewood St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Bradburn,

6-DATE OF BIRTH (month, day and year) March 22. 1862

7-AGE. 65 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Superintendant

(b) General nature of industry, business, or establishment in which employed (or employer). 86

(c) Name of employer. Home Friendly Ins. Co.

9-BIRTHPLACE (city or town) (State or Country), St Mars Co. Md

PARENTS.

10-NAME OF FATHER, Wm. F. Bradburn,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), St Marys Co. Md.

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Jennie C. Bradburn,

(Address) 617 Edgewood St.

15- Filed JUN 16 1927 19 S. HARRISON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 15 1927

17- I HEREBY CERTIFY, That I attended deceased from March, 1925, to 15 June, 1927, that I last saw him alive on 15 June 1927, and that death occurred, on the date stated above, at 5:45 p m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Consultations etc

(Signed) Horace W. Byers M. D.

, 19 (Address) 214 W. Monument ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn JUN 18 1927 19

20-UNDERTAKER, Geo M Little ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 23158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1318 N. Fulton ave ST. 1227 WARD)

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Glazey

(a) RESIDENCE NO. 1318 N. Fulton ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline M.

6 DATE OF BIRTH (month, day, and year) July 29-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired) Ohio

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. W. Glazey Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Caroline M. Glazey

(Address) 1318 N. Fulton ave

15 Filed JUN 16 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1926 to June 14 1927.

that I last saw him alive on June 14 1927

and that death occurred, on the date stated above, at 7.55 P. m

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Jan. 1926

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs & Microscopic exam. of tissue

(Signed) ..... M. D.

, 19 (Address) Wheeler 1013 Cathedral Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 17 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St.

HAMPSON JONES, M.D.

TION is very important See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23159 — 1-PLACE OF DEATH

E 23159 — REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 17-25 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Miller

(a) RESIDENCE NO. 514 N Paca st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of Frances Miller

6 DATE OF BIRTH (month, day, and year) Aug 12 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.,
	74	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ? Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Switzland

12 MAIDEN NAME OF MOTHER Frances Colholz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Relative

15 Filed ..... 19 ..... Registrar

JUN 16 1927 RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1926, to June 15, 1927

that I last saw h-m alive on June 15, 1927

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sob.

(Signed) R. Hooper Smith M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Redeemer Cemetery — Date of Burial June 17 1927

20 UNDERTAKER Robt J Turner Sr — ADDRESS 2342 Broadway

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23160

E 23160

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 Somerset ST. 5-6 WARD)

2-FULL NAME Sarah Cephas

(a) RESIDENCE NO. 519 Somerset ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16. 1912.

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or..... min.
	14 15	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Cephas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alice May Brunch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Harry Cephas (Father) (Address) 519 Somerset st

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1926, to June 13, 1927, that I last saw h[illegible] alive on June 13, 1927, and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Young, M. D.

6/15, 1927 (Address) 1429 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL June 17 19

20 UNDERTAKER Mrs. P. G. Elliott ADDRESS 720 Lanvale

JUN 16 1927

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23161

37-002

E 23161

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (Loc.) St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Richardson

(a) RESIDENCE NO. 224 N. Bethel st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER David Richardson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bermuda

12 MAIDEN NAME OF MOTHER Drusilla Lomax

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 16 1926 16 HAMILTON JONES, M. D. Registrar

By RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 27, 19, to June 13, 27, 19.

that I last saw him alive on June 13, 19 27

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis? [illegible]

(Signed) W. E. Gattens, M. D.

6-14-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
Laurel Cemetery	
20 UNDERTAKER Mrs. A. G. Elliott	ADDRESS 222 Lafayette Ave

Be sure to print forms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Bacon St Paul 2016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23162   E 23162

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 East North St. 12-19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis H Trogler

(a) RESIDENCE NO. 207 East North St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 29 1912

7 AGE — Years: 15 Months: 3 Days: 16 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Cincinnati

(State or country): Ohio

PARENTS

10 NAME OF FATHER: H. J. Trogler

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Christine Patterson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Cincinnati Ohio

14 Informant: H. J. Trogler

(Address): 207 East North.

15 Filed JUN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1927, to June 15, 1927,

that I last saw h[illegible] alive on June 15, 1927,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary): Chorea

(duration) yrs. 4 mos. 12 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs of Endocarditis

(Signed) Walter C Bacon M. D.

4/16/27 (Address) 100 E 20th St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: June 18 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23163 — 1-PLACE OF DEATH

E 23163 — REGISTERED NO.

City of BALTIMORE: (No. 911 Eden st (Garage) St., 16-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Leddon

(a) RESIDENCE NO. 841 N. Central Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Leddon

6 DATE OF BIRTH (month, day, and year) Dec 10/1880

7 AGE	Years	Months	Days 4	IF LESS than 1 day.....hrs. or.....min.
	46	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chafieur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bonif Drane Co

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Wm. B. Leddon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Ida Wooden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs Rosa Leddon

(Address) 841 N. Cent Ave

15 Filed JUN 15 1927 19 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 192 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in brain

Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Jos H Carter M. D.

(Coroner)

6/16/27 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial June 17 1927

20 UNDERTAKER William Cook ADDRESS 501 E North Ave

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128E 23164

1-PLACE OF DEATH

City of BALTIMORE: (No. 632 N. Bruest St. 16-27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Howard Anderson

(a) Residence No. 632 N. Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Anderson

6-DATE OF BIRTH (month, day and year) 1885

7-AGE. 42 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER. Robt Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER. Annie Anderson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Viola Anderson

(Address) 632 N. Bruest

15- Filed ... 192 ... Registrar.

C. HARRISON JONES, M. D.

NOV 1927 Per RK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-13-27

17- I HEREBY CERTIFY, That I attended deceased from 6-4-, 1927, to 6-13-, 1927, that I last saw h[illegible] alive on 6-13-, 1927, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) A. Ward Williams M. D.

6-15-, 1927 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pt Cumberland

DATE OF BURIAL. June 16 27

20-UNDERTAKER Emmert B. Hensley

ADDRESS 57 N Eddie

Instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 23165

CERTIFICATE OF DEATH.

E 23165

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Rodgers

(a) RESIDENCE NO. 304 N Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865 -

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Lizzie Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible] 19[illegible]

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1927

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to June 13, 1927, that I last saw him alive on June 13, 1927, and that death occurred, on the date stated above, at 1:45 p m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency (Luetic)
Myocardial hypertrophy and
Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? genual & laboratory

(Signed) R. Hooper Leavitt, M. D.

June 13 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Asbury cemetery June 17. 1927

20 UNDERTAKER — ADDRESS

Milton. Davis 316. N Eden St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23166

CERTIFICATE OF DEATH.

186-003

E 23166

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Moisan

(a) RESIDENCE NO. 215 West Lanvale St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Moisan

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	26	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John H. Ehrhardt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Gertrude Wade

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Charles Co., Md.

14 Informant John H. Ehrhardt

(Address) 302 Ready Ave.

15 Filed JUN 16 1927 19 C. HAMPSON JONES, M.D. Registrar

By K.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gangrene-amputation both legs
Gas Bacillis infection. Automobile accident Phila Road. Balto. Co.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

6/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial June 17 19 27

20 UNDERTAKER Henry W. Means & Son ADDRESS 805 N. Calvert St.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23167 — 164-001 — E 23167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. [illegible] WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sadilek ✓ girl

(a) RESIDENCE NO. Penal Md ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year) 6-14-27

7 AGE — Years: — Months: — Days: — If LESS than 1 day, 4 hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Franklin Sq Hosp

PARENTS

10 NAME OF FATHER Joe Hutchison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Mary Sadilek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): C HAMPSON JONES, M.D.

15 Filed JUN 16 1927 No. 1462 Registrar RPS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 15, 1927, that I last saw her alive on June 15, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature
Respiratory failure

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) 4h 5 min.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) W W Allen Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23168 66 E 23168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William N. Cannon

(a) RESIDENCE NO. 308 S. 13th St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Sadie E. Cannon

6 DATE OF BIRTH (month, day, and year) Sept 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	52	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethelem Steel Co

9 BIRTHPLACE (city or town)

(State or country) Concord Del

PARENTS

10 NAME OF FATHER Isaac S. Cannon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Sussex C., Del

12 MAIDEN NAME OF MOTHER Mary E. Kelly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Creek Del

14 Informant Everett C. Cannon Son

(Address) 308 S. 13th St

15 Filed JUN 6 1927 Registrar

16 Filed JUN 6 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Jos H Pitts M. D.

(Coroner)

19 6/16/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Concord Del Date of Burial June 17, 1927

20 UNDERTAKER W. C. Watson ADDRESS Seaford, Del.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 23169

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 1/2 E. Hamilton St. Hamilton WARD) REGISTERED NO. 190

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Christopher

(a) RESIDENCE No. 107 1/2 E. Hamilton ave. Hamilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Christopher

6 DATE OF BIRTH (month, day, and year) Jan. 1st 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Lula Nichols (Address) 107 1/2 E. Hamilton ave.

15 Filed JUN 16 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1927, to June 14, 1927, that I last saw h alive on June 14, 1927, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Pericardilis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Wright Long, M. D.

6/14, 1927 (Address) 2 W. Hanford Rd Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL June 17 1927

20 UNDERTAKER Frederick Lacasta ADDRESS Fulton

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23170

CERTIFICATE OF DEATH.

E 23170

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. Ward) 28-65

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Lemming

(a) RESIDENCE NO. Mason Mill Rd. & Frost Park Ward Pikesville, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Lemming

6 DATE OF BIRTH (month, day, and year) March 12th 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionary

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Co. June 15, 1927 (Address) 2802 Edmondson Ave.

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Lemming

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Unknown Virginia

12 MAIDEN NAME OF MOTHER Barbara Stoer

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.

(State or country) Maryland

14 Informant Mrs E Lemming

(Address) Hillsdale, Md R. D.

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) under treatment

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessey M. D.

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zion Lutheran Cemetery Date of Burial: June 18 1927

20 UNDERTAKER: Frederick Lassahn & Sons ADDRESS: Fulton

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Wyprecht

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001 V.

E 23171

CERTIFICATE OF DEATH

E 23171

1-PLACE OF DEATH

REGISTERED NO. 19-28

City of BALTIMORE: (No. 432 S Parrish St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Wyprecht

(a) RESIDENCE NO. 432 S Parrish St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	41	9	21 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Julian Wyprecht

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Dorothy Kruszewski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Julian Wyprecht

(Address) 432 S Parrish St

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

By MCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Jun 14, 1927.

that I last saw him alive on Jun 14, 1927.

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Edema of Abdomen

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Neurosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathan A. Dunn, M. D.

, 19 (Address) 1227 Mosher Bldg

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Rosary Cem — Date of Burial June 17 19 27

20 UNDERTAKER John M Weber — ADDRESS 803 Gough St

IF DEATH IS DUE TO VIOLENCE, state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23172

CERTIFICATE OF DEATH.

90 E 23172

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2310 Essex St St., 1-3 Ward)

2-FULL NAME Stanislaus Bratowski

(a) RESIDENCE NO. 2310 Essex St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 / yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bratowski

6 DATE OF BIRTH (month, day, and year) July 20/1884

7 AGE	Years	Months	Days 25	IF LESS than 1 day.....hrs. or.....min.
	42	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker M

(b) General nature of industry, business, or establishment in which employed (or employer) 06

(c) Name of employer self

9 BIRTHPLACE (city or town) _____

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Mary Bratowski

(Address) 521 S. Milton Ave

15 Filed 6/16/1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. M. Pell M. D.

(Coroner)

6/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos., ___ ds. In the State ___ yrs., ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial June 15 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Booth

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23173

CERTIFICATE OF DEATH.

84 E 23173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 East 34th.St ST., 9-47 WARD)

2-FULL NAME George H. Sprague

(a) RESIDENCE No. 509 East 34th.St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Late Jennie Smith Sprague

6 DATE OF BIRTH (month, day, and year) Feb. 8th. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	85	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Pilot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown Sprague

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Aimee H Jones

(Address) 509 East 34th.St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927, to June 16, 1927

that I last saw him alive on June 16, 1927

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. R. Campbell M. D.

June 16, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL June 18 1927

20 UNDERTAKER Harry A Weitze

ADDRESS 1520 Linden

Spec.–7-17-26—A Co.—200 Bks.

E 23174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23174

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hosp. for Women of Md. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Zorbach Schnauffer

(a) RESIDENCE NO. 527 York Road, Towson Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Frederick William Schnauffer

6 DATE OF BIRTH (month, day, and year)
June 21 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Zorbach
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER not known
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) not known

14 Informant William S. Schnauffer (Son)
(Address) 527 York Road, Towson

15 Filed JUN 7 1927, 19 (Signed) HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927
June 15

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to June 15, 1927, that I last saw her alive on June 15, 1927, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of breast, left.
(duration) 2 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Pulmonary embolism.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 18, 1927
Was there an autopsy? No.
What test confirmed diagnosis? Microscopic exam.
(Signed) H. H. Krock, M. D.
, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial June 9, 1927

20 UNDERTAKER John Burns Sons ADDRESS Towson

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Fill in all items, so that it may be properly classified. CAUSE OF DEATH in plain terms,

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23175 46 ✓ E 23175

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp 16-23 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Gozuk -

(a) RESIDENCE NO. 1118 N Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col -	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Willie Young.

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Alice Wright

(Address) 1118 N. Caroline ave

15 Filed JUN 17 1927, 19 Per

CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-27

17 I HEREBY CERTIFY, That I attended deceased from 5-27-, 1927 to 6-15-, 1927

that I last saw h alive on 6-15-, 1927

and that death occurred, on the date stated above, at 9 00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva

(duration) 1 mos. 15 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Physical Signs

What test confirmed diagnosis? Surg.

(Signed) H. Engelke, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill Cem Date of Burial June 17 1927

20 UNDERTAKER Daniel Carton ADDRESS 946 Ba ave

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23176

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 23176

REGISTERED NO.

City of BALTIMORE: (No. 1363 Whatcoat St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Hayes

(a) RESIDENCE NO. 1363 Whatcoat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas Hayes

6 DATE OF BIRTH (month, day, and year) Feb 11 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) U. S.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Parkerson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

14 Informant John Parker

(Address) 1363 Whatcoat St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 19 27

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to June 15, 1927, that I last saw h.. alive on June 13, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbram Frey, M. D.

June 16, 1927 (Address) 1908 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklin Woods Cemetery Date of Burial 6/17 19 27

20 UNDERTAKER Mt Auburn Cemetery ADDRESS 709 W 33 St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23177

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 23177

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St.) (Ward)

2-FULL NAME Elwood Cockey

(a) RESIDENCE NO. 598 W. Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 28 1926

7 AGE: Years: Months: 4 Days: 18 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Clearance Cockey

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Estella Howard

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Clearance Cockey

(Address) 598 W. Preston St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Terminal)

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) .....yrs. .....mos. .....ds.

(Signed) C. HAMPSON JONES, M. D. (Coroner)

6/17/27 19 (Address) 503 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial: June 19 27

20 UNDERTAKER: Mrs. R. M. Elliott ADDRESS 1725 Ashland Ave.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23178

CERTIFICATE OF DEATH.

186-003 ✓ E 23178

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 N. Chapel St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie Eichler

(a) RESIDENCE NO. 1600 N. Chapel St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late George Eichler

6 DATE OF BIRTH (month, day, and year) Dec 12/1862

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Gerech Eichler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Arthur Eichler

(Address) 1600 N. Chapel St

15 Filed _____, 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocardial Failure. Automobile Accident May 29/27 at New Market, Pa (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. T. Owens (Coroner) M. D.

6/17/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mathews — Date of Burial 6/19 1927

20 UNDERTAKER L. Heemann — ADDRESS 3x S Bway

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23179

CERTIFICATE OF DEATH

46

E 23179
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 802 E 20th ST. 9-46 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gay Cornelia Seward

(a) RESIDENCE NO. 802 E 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, ~~Widowed~~, or Divorced. (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A Seward

6 DATE OF BIRTH (month, day, and year) Jan 30-1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
37	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Cornelius VanHeusen

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Gabriella Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Wm A Seward

(Address) 802 E 20th St

15 Filed JUN 17 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to June 16, 1927,

that I last saw h alive on June 16 1927,

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Robert E. Friedel, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Dorchester Co Md — DATE OF BURIAL June 17th 1927

20 UNDERTAKER Bertram F Lore — ADDRESS 1723 W Lafayette Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23180

CERTIFICATE OF DEATH

E 23180

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 10-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sda Armwood

(a) RESIDENCE NO. 925 Stirling St. Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Jerry Holmes

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Amanda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant James Armwood

(Address) 700 E Chase St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-14-27

17 I HEREBY CERTIFY, That I attended deceased from 5-21-, 1927, to 6-14-, 1927.

that I last saw h[illegible] alive on 6-14 19 27

and that death occurred, on the date stated above, at 3 7/8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — Date of Burial June 18 1927

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See, instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23181

CERTIFICATE OF DEATH.

188-003 ✓

E 23181

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St. 3-5 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Levin

(a) RESIDENCE NO. 123 S, Exeter St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 35 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Levin

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Mr. Ellis Levin.

(Address) 123 S. Exeter St.

15 Filed JUN 7 1927, 19 Per [signature] Registrar

H. HAMILTON JOHNS, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 6-17-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Struck by automobile at Albemarle & pratt

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

6/17/27 (Address) 508 E. Fort h Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Harmon Rem Date of Burial 6-11-1927

20 UNDERTAKER Jack Levin ADDRESS 1139 E. Balt.

Be sure to write in pencil (Copy), so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23182

CERTIFICATE OF DEATH.

E 23182
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 547 S. Fulton St., 1928 WARD)

2-FULL NAME Solomon Passen

(a) RESIDENCE NO. 549 S. Fulton a ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jennie Passen

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	73	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lehrer
(b) General nature of industry, business, or establishment in which employed (or employer) Teacher
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Faib Passen
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Jennie —
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Albert Passen
(Address) 547 S. Fulton Ave

15 Filed JUN 17 1927, 19 By
(C. HAMPSON JONES, M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1925, 19 , to June 16, 1927, that I last saw h[illegible] alive on June 16, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart disease (Mitral Stenosis)
(duration) 2 yrs. mos ds.
CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Signs & symptoms
(Signed) M Chadecker, M. D.
, 19 (Address) 2225 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Keppen Rum
DATE OF BURIAL 6/17 1927
20 UNDERTAKER Jack Lewis
ADDRESS [illegible]

ATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 ✓

CERTIFICATE OF DEATH.

E 23183
1-PLACE OF DEATH

REGISTERED NO. E 23183

City of BALTIMORE: (No. St Agnes Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bessie Lubicki

(a) RESIDENCE NO. 117 N Front St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 2 yrs. 5 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex Lubicki

6 DATE OF BIRTH (month, day, and year) Nov. 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
29 30		2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Godman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia Silverman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Alex Lubicki

(Address) 117 N. Front St.

15 Filed 6-17 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-16-27

17 I HEREBY CERTIFY, That I attended deceased from 4-8- 19 27, to 6-16 19 27, that I last saw her alive on 6-16 19 27 and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Jno. J. Gibbons, M. D.

6/16/27 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run Date of Burial 6/17 1927

20 UNDERTAKER Sol Kinsor & Bro ADDRESS 1161 E Balto St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23184

E 23184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Halcyon Park Road ST.) 27-44 (WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Thorn

(a) RESIDENCE No. 6 Halcyon Park Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Thorn

6 DATE OF BIRTH (month, day, and year) July 26 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder 016

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas J. Thorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Henrietta Haney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mary A. Thorn

(Address) 6 Halcyon Park Road

15 Filed JUN 17 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1926, to June 16. 1927.

that I last saw him alive on June 15. 1927

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

about (duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) D W Jones, M. D.

6/16/1927 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL June 20 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1739 E. Eager St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 23185

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray H Hamill

(a) RESIDENCE NO. 2956 Staunton Rd St. Ward Huntington W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie

6 DATE OF BIRTH (month, day, and year) 1-7-87

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
43	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) (Md.) Maryland.

PARENTS

10 NAME OF FATHER H-Hamill

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hoffel-

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Ellie M Hamill Reside-

(Address) JOHNS HOPKINS HOSPI

15 Filed ....., 19 C H HAMILTON JONES, M. D. Registrar

For R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 16, 1927, that I last saw him alive on June 16, 1927, and that death occurred, on the date stated above, at 2.45 P- m.

The CAUSE OF DEATH* was as follows:

Dysentery following operation for nephrolithiasis right.

4 (duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) nephrolithiasis

(duration) 1 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Huntington W Va ?

Did an operation precede death? yes Date of June 13.

Was there an autopsy? yes

What test confirmed diagnosis? ....

(Signed) Edw A Kelly, M. D.

6-16, 1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington W. Va Date of Burial June 18 1927

20 UNDERTAKER John O. Mitchell ADDRESS Lore 190 Eutaw Pl

very important. See instructions on back of certificate. EXACT STATEMENT OF OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 23186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 23186

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 W Lombard St. 18-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Goettken

(a) RESIDENCE NO. 1240 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Goettken

6 DATE OF BIRTH (month, day, and year) April 21st 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Goettken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Goettken

(Address) 1240 W Lombard st

15 Filed JUN 17 1927 19

C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1926, to June 15, 1927, that I last saw him alive on June 14, 1927, and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) W. H. Triplett, M. D.

19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemty — DATE OF BURIAL June 18 1927

20 UNDERTAKER Kemp & Fields — ADDRESS 1200 W Lombard st

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23187

CERTIFICATE OF DEATH

129

E 23187

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3 Quick Ave St., Raspberry 26-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Oelke

(a) RESIDENCE NO. 3 Quick Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Oelke

6 DATE OF BIRTH (month, day, and year): Feb 2. 1848

7 AGE: Years 78 — Months 8 — Days 13

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 25 yrs

(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco Factory

(c) Name of employer

086

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Mr John G Oelke

(Address) 3 Quick Ave

15 Filed JUN 1 1927, 19 C. JAMESON JONES, M. D.

Registrar

Per R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 27, to June 15, 19 27, that I last saw h[illegible] alive on June 14/27 19 , and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis of Kidneys

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Uremia

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. J. Jones, M. D.

6/18/27 19 (Address) 6 W Mt Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

Date of Burial: June 18 1927

20 UNDERTAKER: John Merrick

ADDRESS: 208 Preston

IMPORTANT: Physician must write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Meiere

Spec.-7-17-26—A Co.—200 Bks.

E 23188

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 23188

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

City of BALTIMORE: (No. 1724 N. Calvert St. 7-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas McKean Meire

(a) RESIDENCE NO. 1724 N. Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 9, 1877

7 AGE — Years: 49 Months: 8 Days: 7 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper merchant

(b) General nature of Industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER D. T. Ernest Meire

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Connecticut

12 MAIDEN NAME OF MOTHER Naomi Buchanan

13 BIRTHPLACE OF MOTHER (city or town) Annapolis

(State or country) Maryland

14 Informant FELIX SULLIVAN

(Address) 1724 N. CALVERT ST

JUN 17 1927 HAMILTON JONES, M. D.

15 Filed 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6-10, 1927, to 6-16, 1927, that I last saw him alive on 6-16, 1927, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

abcess wall of caecum -

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) obstruction, Intestinal

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 6-10-27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) R. J. Bedford, M. D.

6-16, 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. ANNES. CEM. ANNOPOLIS

Date of Burial: 6/20/27

20 UNDERTAKER: HENRY W. JENKINS. SONS CO

ADDRESS: ANNAPOLIS. MD.

McCULLOH

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Hiss ✓

E 23189 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23189

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Harford ave ST., 9-45 WARD)

2-FULL NAME Frederica Gude Hiss

(a) RESIDENCE NO. 3202 Harford Ave ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm L. Hiss

6 DATE OF BIRTH (month, day, and year) Feb 5 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Louis Gude

11 BIRTHPLACE OF FATHER (city or town) Saxony (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Cook

13 BIRTHPLACE OF MOTHER (city or town) Saxony (State or country) Germany

14 Informant William J. Hiss (Address) 3202 Harford ave

15 Filed JUN 17 1927 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 19 27, to June 15, 19 27, that I last saw h alive on June 15, 19 27, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Carditis

Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) C W Meyer Jr. M. D.

6/16. 19 27 (Address) 1500 E. 3 Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Mount Cemetery	June 19 19 27
20 UNDERTAKER Henry H Kenkendall	ADDRESS Baltimore

FION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

E 23190

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 9-18 Ward)

2-FULL NAME Gilbert Norris

(a) RESIDENCE NO. 1913 Aisquith St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xxxx 1905

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Silas Norris

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Miles

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant Hattie Norris

(Address) 1913 Aisquith St

15 Filed _____ 19___ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Clinical- Diabetic Coma

Autopsy- Acute Lobular Pneumonia

Early Syphillitic Aortitis

(Duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. E. Miller M. D.

(Coroner)

6/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Arbeary Cemetery	June 17, 1927
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23191

CERTIFICATE OF DEATH.

E 23191

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Webster St. St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Kelly .(C)

(a) RESIDENCE NO. 529 N. Patterson Park Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) 1916.
Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	11	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Kelly.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Johnson.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Lilly Kelly.(C) sister.

(Address) 529 N. Patterson Park Ave.

15 Filed JUN 17 1927 C. HAMPSON JONES, M. D. Registrar

Per K/K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

(Signed) Otto Bernardi M. D.
(Coroner)

6/14, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Lakewood Cemetery June 17, 1927.

20 UNDERTAKER Edward Bryon. ADDRESS Orleans St.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23192

161-0 23192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL S. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thompson

(a) RESIDENCE NO. 1426 Monroe St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years ~~Months~~ Days: 5 minutes IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER William Moore

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

JOHNS HOPKINS HOSPITAL

14 Informant Records

(Address)

15 Filed JUN 14 1927 By C. HAMPSON JONES, M. D. Registrar

1464

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to June 12, 1927, that I last saw her alive on June 12, 1927, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health JUN 14 1927

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

23193

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23193

CERTIFICATE OF DEATH.

16 E 23193

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jewel Bald Hosp

City of BALTIMORE: (No. 1713 S Light St. 43-33 Ward)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. 1306 Light St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6 14 27

7 AGE — Years | Months | Days | IF LESS than 1 day ....hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Howard William Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert County

12 MAIDEN NAME OF MOTHER Lillian Rehling

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co Md

14 Informant

(Address)

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 14, 19 27, to June 14, 19 27, that I last saw h alive on June 14, 19 27, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows: Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Miller, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial 6/17 19 27

20 UNDERTAKER: J. J. Sabey & Sons ADDRESS 1318 Light St

very important. See instructions on back of certificates. Place statement of OCCUPATION in

Spec.—1-12-23—M&T—500 Bks.

E 23194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 E 23194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Thorndale Ave ST.) 17-56 (WARD)

2-FULL NAME Willis H. Landon

(a) RESIDENCE No. 111 Thorndale Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline D. Landon

6 DATE OF BIRTH (month, day, and year) Sept. 22 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 6 yrs.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. D. Landon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Howard L. Landon (Address) Continental Bldg Co Sherwood Bros

15 Filed ... 19 CHAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23 1927 to June 16 1927, that I last saw him alive on June 16 1927, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? — No

What test confirmed diagnosis? —

(Signed) H. S. Jones M. D.

6/17 1927 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 18 1927
20 UNDERTAKER	ADDRESS
Wm Fleckner Sons	Baltimore

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23195

CERTIFICATE OF DEATH.

44 E 23195

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 E North ave ST. 13-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F Boyden

(a) RESIDENCE NO. 700 E North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace M Boyden

6 DATE OF BIRTH (month, day, and year): Jan 4 1867

7 AGE: Years 60 | Months 5 | Days 2 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Civ Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Wm Boyden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Sarah Laughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Grace M Boyden 700 E North

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

Per BSH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from about 6 mos. ago 19 , to June 16, 1927.

that I last saw h in alive on " " , 1927.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of throat (fracture)

about 1 (duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J. T. Shumwell, M. D.

June 17, 1927 (Address) 3316 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: June 18 1927

20 UNDERTAKER: E Le Roy Stiffler — ADDRESS: 1354 Nath

Spec.—1-12-23—M&T—500 Blks.

E 23196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 10-8001 E 23196

1-PLACE OF DEATH U. S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Newell

(a) RESIDENCE NO. 29 Newhall St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Lynn, Mass (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 2-27-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	21	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10 NAME OF FATHER Oscar Newell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self (Address)

15 Filed ..... 19 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 16, 1927, that I last saw him alive on June 16, 1927, and that death occurred, on the date stated above, at 5 45 m.

The CAUSE OF DEATH* was as follows:

Lepto-meningitis, Cerebral

(Exact cause impossible to State until microscopic examination is completed)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia, lobar

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? On Transport

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings, Laboratory tests and autopsy

(Signed) W W Bentz A.A. Surgeon U.S.P.H.S. M. D

(Address) U S Marine Hospital No 9, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's (Hampden) DATE OF BURIAL June 16 1927

20 UNDERTAKER E. E. Boyd Shipley ADDRESS 1252 North Ave

Spec.–7-17-26—A Co.—200 Bks.

Moore ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23197 E 23197

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO. 14.20

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS (C[illegible]) St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Moore

(a) RESIDENCE NO. 1836 McCulloh st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than I day hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Gabriel Hammond

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Ayers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 31, 27, 19, to June 15 27, 19,

that I last saw her alive on June 15, 19 27.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gallahan, M. D.

6-16-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Junction Md.

Date of Burial 6/18/ 1927

20 UNDERTAKER Mrs. Geo. H. Collard

ADDRESS 1607 Druid Hill Ave

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23198

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23198

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph's Hospital

REGISTERED NO. 87

City of BALTIMORE: (No. Caroline & Oliver St., 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hermina H Offmann

(a) RESIDENCE NO. 305 E. 24th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-27-1919

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	7	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Carl H Offmann

11 BIRTHPLACE OF FATHER (City or Town)

(State or country) Vienna Austria

12 MAIDEN NAME OF MOTHER Hermina Rebena

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Carl H Offmann

(Address)

15 Filed 8 1927 C. HARRISON JONES, M. D. Registrar

Per 2755

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927 to June 16, 1927

that I last saw h alive on June 16, 1927

and that death occurred, on the date stated above, at 9:30 p m.

The CAUSE OF DEATH* was as follows:

Pericarditis with Effusion

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Clement R. Manges, M. D.

19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

Date of Burial 6/20 1927

20 UNDERTAKER Mary M. Wiedefeld

ADDRESS 501 2 2nd

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23199

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 23199

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 326 E. 21st St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ernest Carroll

(a) RESIDENCE NO. 326 E. 21st St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fanny Byrd

6 DATE OF BIRTH (month, day, and year): Nov 23 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shell Drawer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hutchinson & Co

9 BIRTHPLACE (city or town): Balt

(State or country): Md

PARENTS

10 NAME OF FATHER: J. A. Carroll

11 BIRTHPLACE OF FATHER (city or town): Balt

(State or country): Md

12 MAIDEN NAME OF MOTHER: J. Booker

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mrs. F. Wagner

(Address): 326 E. 21st St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Morrissey M. D.

Coroner

6/17, 1927 (Address) 6732 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: 6/18 1927

20 UNDERTAKER: Mary M. Wiedefeld ADDRESS: 507 E 22d

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23200

CERTIFICATE OF DEATH.

100-001 ✓ E 23200

1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 Stockton St. 16 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Wright

(a) RESIDENCE NO. 1023 Stockton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. June 17, 1927

(State or country)

PARENTS

10 NAME OF FATHER Henry L Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Mamie Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Henry L Wright

(Address) 1023 Stockton St

15 Filed JUN 18 1927 19 C. HAMPSON JONES, M. D. Registrar

BY _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

1927 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial June 20 1927

20 UNDERTAKER Hanna & Wright ADDRESS 1634 Mary

Cut on plain lines, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 23201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr. Kirk
3126 Hartford Rd
E 23201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 35 Schaffer Ave St. (Hamilton) Ward) 43

2-FULL NAME Frances Wiley

(a) RESIDENCE NO. 35 Schaffer Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Wiley

6 DATE OF BIRTH (month, day, and year) Sept 14. 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Abendschein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Fritsch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Oscar Schaffe

(Address) 35 Schaffer Ave

15 Filed G. HAMILTON JONES, M. D. Registrar

1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1926, to June 15th 1927, that I last saw h alive on June 13th 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

Carcinosis (duration) yrs. mos. 16 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

6/17. 1927 (Address) 3126 Hartford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

1st Evangelical Lem. June 19 1927

20 UNDERTAKER — ADDRESS

H. Sander Sons Inc 1710 East ll

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23202

CERTIFICATE OF DEATH.

117 E 23202

1-PLACE OF DEATH The Church Home & Infirmary

REGISTERED NO.

City of BALTIMORE: (No. 7-13 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Weber

(a) RESIDENCE NO. 2005 Ashland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Weber

6 DATE OF BIRTH (month, day, and year) Sept 25. 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Martin Weber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Koch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant

(Address) 2005 Ashland Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-16-27

17 I HEREBY CERTIFY, That I attended deceased from 5-4-27, 19, to 6-16-27, 19, that I last saw h[illegible] alive on 6-16-27, 19, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Appendicitis acute gangrenous

Peritonitis general

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar 1 week

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? Yes Date of 26 May 27

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Harry O'C Wilson, A. M. M. D., M. D.

, 19 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Lorraine Cemetery June 19 1927

20 UNDERTAKER ADDRESS

H. Sander & Sons 1710 E. Lexington St

JUN 1927 C. HARRISON JONES, M. D. Health Officer

N.B.

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23203

CERTIFICATE OF DEATH

75-201

E 23203

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 W.Ostend St., 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Kromm

(a) RESIDENCE NO. 5 W.Ostend St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Kromm

6 DATE OF BIRTH (month, day, and year) Dec.10 1848

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	78	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country) Germany

PARENTS

10 NAME OF FATHER David Scharmann

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Kaiser

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Germany

14 Informant Adam Kromm

(Address) 5 W.Ostend St.

15 Filed 8 1927 16 C. HAMPSON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927 19...

17 I HEREBY CERTIFY, That I attended deceased from June 5/27, 19..., to June 16/27, 19..., that I last saw him alive on June 16/27, 19..., and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral) ... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hyp Blood Pressure & Arteriosclerosis (duration) Not Known yrs. ... mos. ... ds.

18 Where was disease contracted ...

If not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) John B Kolb M. D.

June 17/27 (Address) 1103 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial June 20 1927

20 UNDERTAKER John T. Denny — ADDRESS 715 Lights St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23204

CERTIFICATE OF DEATH.

E 23204

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 2707 Westwood ave ST. 15-21 WARD)

2-FULL NAME Mildred Thomas Joseph Coons

(a) RESIDENCE. No. 2707 Westwood ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, ~~Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Isaac Ross Coons

6 DATE OF BIRTH (month, day, and year): June 14 27

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Isaac Coons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): I. R. Coons 2707 Westwood ave

15 Filed JUL 8 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per 1467 RRD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1927, to June 17, 1927, that I last saw h alive on June 17, 1927, and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Injury in birth

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Mal presentation, Delivery,
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

. 19 (Address) 303 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

Please do very important! See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23205

CERTIFICATE OF DEATH.

74-001 E 23205

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Johns Hopkins Hospital St., _____ Ward)

2-FULL NAME Cledella Williams

(a) RESIDENCE NO. 2654 Boone St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Williams

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Pvt

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Va.

PARENTS

10 NAME OF FATHER Archie Woodland

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant George Williams Jr

(Address) 2654 Boone St.

15 Filed June 20 1927 C. HAMPSON JONES, M. D.

Per R P G Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Autopsy at Hopkins)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Obesity & Arteriosclerosis

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. K. Watts M. D.

(Coroner)

(Address) 508 E Madison

6/15/27 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial June 19 1927

20 UNDERTAKER Mrs R. G. Elliott ADDRESS 1225 Eutaw

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 23206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23206

1-PLACE OF DEATH 3708 Callaway Ave, 129

CITY OF BALTIMORE: (No. 15-62 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Hoover.

(a) RESIDENCE NO. 3708 Callaway Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Catherine Kercheval.

6 DATE OF BIRTH (month, day, and year) Aug 3 - 1850 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John C Hoover.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Lennold.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Wm E Hoover (Address) 3708 Callaway Ave

15 Filed 6/18 1927 C. HAMPSON JONES, M. D. Registrar

Per H.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 17, 1927.

That I last saw h in alive on June 17, 1927.

and that death occurred, on the date stated above, at 2.55 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 10 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) 5 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Geo. C. Shannon, M. D.

6/18 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 6-20-27.

20 UNDERTAKER Martin Fahey Sons — ADDRESS 827 W Mattle Ave.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23207

CERTIFICATE OF DEATH

90 E 23207

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4725 Locust Ave St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Chipman

(a) RESIDENCE NO. 4725 Locust Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of William H. Chipman

6 DATE OF BIRTH (month, day, and year): April 22 1845

7 AGE — Years: 82 Months: 1 Days: 24

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: William Mann

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ann Waite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: W. H. Chipman (Son)

(Address): 4725 Rockett Ave

15 Filed JUN 18 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 16, 1927.

that I last saw h alive on June 16th 1927.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lordy M. D.

6-17. 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Date of Burial June 18 1927

20 UNDERTAKER: Wm Cook & Sons ADDRESS E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23208

113 E 23208

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 835 Hamilton Ter St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wade H. Grim

(a) RESIDENCE NO. 835 Hamilton Terr St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wade H. Grim

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Pitsenbarger

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va.

14 Informant Mrs. Wade H. Grim

(Address) 835 Hamilton Terr

15 Filed 1927 C. HAMPSON JONES, M. D.

By _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

June 17, 1927 (Address) 780 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial June 18 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 23209

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 1124 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Grimm

(a) RESIDENCE NO. 535 Hamilton Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1920

7 AGE: 4 Years 5 Months 10 Days 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va. June 17

(State or country)

PARENTS

10 NAME OF FATHER Walter M. Grimm

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz. Pitsenbarger

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant Wesley M. Grimm

(Address) 535 Hamilton Ter

15 Filed ....., 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) automobile accident

(duration) ..... yrs. ..... mos. ..... da.

(Signed) J. J. Kenney M. D.

(Coroner)

June 17, 19 27 (Address) 502 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Virginia Date of Burial 6/18/27 19

20 UNDERTAKER: Wm Cook ADDRESS 502 E Northern

1927 G. HAMPSON JONES, M. D.

Reg.

If the space is not sufficient, use the reverse side. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 23210

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 23210

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Bender Bodenbender

(a) RESIDENCE NO. 1729 Bradford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Bodenbender

6 DATE OF BIRTH (month, day, and year): Aug 11 1864

7 AGE: Years 62 (62) Months 10 Days 5

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Henry Bodenbender

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs John Hilsch

(Address) 1724 N Bradford St

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-16-27

17 I HEREBY CERTIFY, That I attended deceased from 6-13-27 19 to 6-16- 1927

that I last saw him alive on 6-16- 1927

and that death occurred, on the date stated above, at 5.00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus -

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 6-15-27

Was there an autopsy? No

What test confirmed diagnosis? Oesophagoscopy -

(Signed) W Bayard Clark M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: 6-20 1927

20 UNDERTAKER: E T B Harle — ADDRESS: 115 E West St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23211

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Dolphin ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Lee

(a) RESIDENCE NO. 552 Dolphin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aquilla Lee

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Aquilla Lee

(Address) 552 Dolphin St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1927

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1927, to June 15, 1927, that I last saw him alive on June 15, 1927 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Shelley, M. D.

6/18, 1927 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL June 18 27

20 UNDERTAKER Emmett F. Linsley

ADDRESS 1711 Eutaw

JUN 18 1927 G. HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 E 23212

CERTIFICATE OF DEATH.

100-001

E 23212

17-24

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. ____ Ward)

REGISTERED NO. ____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Minor

(a) RESIDENCE NO. 1314 Mayfield Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa Minor

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50 49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Wm Minor Sr.

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Rose Hazard

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSP.

15 Filed ____, 19____ C. HAMPSON JONES, M. D. Registrar

Par 1877

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 23, 1927, to June 17, 1927, that I last saw him alive on June 17, 1927, and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
Hypertension
Emphysema

(duration) 5 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ____ yrs. ____ mos. 6 5 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? ____

(Signed) Chas. H. Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Remover Co Md. Date of Burial June 19 27

20 UNDERTAKER James H. Wesley ADDRESS 5 Biddle St

very important. See instructions on back of certificates. Full statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23213

CERTIFICATE OF DEATH

E 23213

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5337 Dennison Ave. 27-55 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Waters

(a) RESIDENCE NO. 5337 Dennison Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Waters

6 DATE OF BIRTH (month, day, and year) May 10 - 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ballo Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Taylor

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Robt L Waters

(Address) 5337 Dennison Ave

18 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927 to June 16, 1927

that I last saw h.. alive on June 13, 1927

and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. 5 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. W. Fletcher M. D.

6/17. 1927 (Address) 1121 Pendleton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

Date of Burial June 18 1927

20 UNDERTAKER Samuel Stanley

ADDRESS 578 Mosher St

JUN 18 1927

C. HAMPSON JONES, M. D.

Registrar

Be sure to print terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23214

CERTIFICATE OF DEATH

57 E 23214

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Davidge

(a) RESIDENCE NO. 500 Mary St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgiana Beatrice Davidge

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years: 60 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): 056

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER Emil Davidge

11 BIRTHPLACE OF FATHER (City or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Delia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant: Ethel Davidge

(Address) 855 Penna Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to June 13, 1927

that I last saw him alive on June 13, 1927

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene, Right Foot, Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of May 29, 1927

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. Blacer M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

Date of Burial: June 18 1927

20 UNDERTAKER: Samuel Hensley

ADDRESS 5 Middle

C. CLARENCE JONES, M. D.

JUN 1927

RPH

Be careful in printing, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23213

CERTIFICATE OF DEATH.

74-001

E 23215

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Univ. Hospital Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie May Lepton

(a) RESIDENCE NO. 211 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19th 1879

7 AGE Years 47 Months 9 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa

PARENTS

10 NAME OF FATHER John Watson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Easter Campbell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Mrs V. Sill

(Address) 211 N. Monroe St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 10 min

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

June 17 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 20 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23216

E 23216

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 Taney Road. 27-55 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie E. Reilly.

(a) RESIDENCE NO. 117 Taney Road. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of George A. Reilly.

6 DATE OF BIRTH (month, day, and year) July 16th. 1878

7 AGE	Years	Months	Days
	48 yrs	11	01

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 027

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.

(State or country)

PARENTS

10 NAME OF FATHER Wallace C. Davidson

11 BIRTHPLACE OF FATHER (City or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary A. Davidson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston. W.Va

14 Informant George A Reilly. (Address) 117 aney Road.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

8 1927 Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5 1927, to June 16 1927, that I last saw h[illegible] alive on June 16 1927, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

. 19 (Address) 1102 No. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem Date of Burial June 28 1927

20 UNDERTAKER J. Ahrens Co. ADDRESS 2432 Eist'n Rd.

J. Ahrens & Co

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23217

CERTIFICATE OF DEATH.

E 23217

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3104 Oakfield Ave (St.) (15-45 Ward)

2-FULL NAME Leah Levy

(a) RESIDENCE No. 3104 Oakfield Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: X

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Levy

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE — Years: 60 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind nf work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs. Goldie Lantz (Address) 3104 Oakfield Ave

15 Filed 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1925, to June 17th, 1927, that I last saw h alive on June 17th, 1927, and that death occurred, on the date stated above, at 12:20 A. m.

The CAUSE OF DEATH* was as follows:

Gasto-Hepatic Malignancy

(duration) yrs. 6 mns ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease cntracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abramson, M. D.

6/19, 1927 (Address) 7360 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 6/19 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore

C. HAMPSON JONES, M. D.

JUN 18 1927

HOW IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23218 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001

CERTIFICATE OF DEATH. 118 E 23218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. St. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Foreman

(a) RESIDENCE NO. 1721 20 Poyson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND (or) WIFE of Lena Forman

6 DATE OF BIRTH (month, day, and year) 10/23/1880

7 AGE: Years 47 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholstery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Meyer Forman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Julia Bernet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): West Balt. Gen. Hosp Russia

15 Filed JUN 19 1927 H. C. HARTMAN JONES, M. D. Registrar

For RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17/27

17 I HEREBY CERTIFY, That I attended deceased from 5/4, 1927, to 6/17, 1927, that I last saw him alive on 6/17, 1927, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows: Post operative intestinal obstruction

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. 1 mos ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5/20/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) Arnold L. Jensen M. D.

(Address) West Balt. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rest

DATE OF BURIAL: 6/19 1927

UNDERTAKER: Jack Laurs

ADDRESS: 1439 E. Baltimore

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23219 E 23219

CERTIFICATE OF DEATH.

91-50 17-50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3209 N. Charles ST. WARD)

2-FULL NAME Henry Stevens Hopkins

(a) RESIDENCE No. 3209 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary B. Hopkins

6 DATE OF BIRTH (month, day, and year): Aug 21, 1863

7 AGE: 63 Years | 11 Months | 26 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winchester Virginia

PARENTS

10 NAME OF FATHER: W.E. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Winchester Virginia

12 MAIDEN NAME OF MOTHER: Louisa Kimball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia Pa

14 Informant: R. M. Allison Jr. (Address) 208 Thompson Road

15 Filed JUN 19 1927, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10th, 1927, to June 17th 1927, that I last saw h live on June 17th, 1927, and that death occurred, on the date stated above, at 3-45 P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Glaucoma & Both Eyes (duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? "

(Signed) Jefferies Buck, M. D.

6/18, 1927 (Address) 5 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: June 20th 1927

20 UNDERTAKER: Harry L. Perkins Inc. ADDRESS: Eutaw & Lanvale

V5

Spec.—12-9-25—A Co.—200 Bks.

-67

E 23220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED E 23320

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~JOHNS HOPKINS HOSP~~ PETTIGREW St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Williams

(a) RESIDENCE NO. Havana, Cuba St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or wife of~~) Alice Dyer Williams

6 DATE OF BIRTH (month, day, and year) November 1st 1881

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
45	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S. Carolina

PARENTS

10 NAME OF FATHER Stephen Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Jane Pellegrem

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. Carolina

14 Informant Records

(Address) ~~JOHNS HOPKINS HOSP.~~

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927.

17

I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 17, 1927, that I last saw h~~im~~er alive on June 17 - , 1927, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor,
Glioma, benign

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/13/27

Was there an autopsy? No Operation

What test confirmed diagnosis?

(Signed) George Y. Finney, M. D.

6/17/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas. Gm. Garrison Forest. Date of Burial: June 20 1927

20 UNDERTAKER: Henry W Venkin + Sons ADDRESS: Richard McCallon

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23221

CERTIFICATE OF DEATH.

74 E 23221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Mallow Hill ST. 28-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. D. Hall

(a) RESIDENCE NO. 24 Mallow Hill ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Israel Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salem N. J.

12 MAIDEN NAME OF MOTHER Mary Bynum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Emmit R Hall 24 Mallow Hill

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 18, 1927.

that I last saw h[illegible]ive on June 17, 1927.

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? Usual signs

(Signed) J. H. Young M. D.

, 19 (Address) 1405 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 21 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 1532 Stollings Ave

NOV 9 1927

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23222

CERTIFICATE OF DEATH.

91-002

E 23222

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 W. Mulberry St.) 19-27 (WARD)

2-FULL NAME Sarah A. Hynes

(a) RESIDENCE No. 1913 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas M. Hynes

6 DATE OF BIRTH (month, day, and year) June 2, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	77		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Curley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jane Hynes, (Address) 1913 W. Mulberry St.

15 Filed JUN 18 1927, 19 Registrar R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1925 to June 16, 1927, that I last saw her alive on June 16, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Kavanaugh, M. D.

6/18/1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL 6/19/27

UNDERTAKER George E Farley Funeral Parlors

ADDRESS

THIS IS very important. See instructions on back of certificates.

Via PENN. R.R. – ESCORT, WM. D. CLARKE.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23223

CERTIFICATE OF DEATH.

E 23223

REGISTERED NO

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1424 St Paul (St.) 12-19 (Ward) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Turner Clarke

(a) RESIDENCE. NO. 1626 St Paul ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of William Hanbury Clarke

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Maryland

PARENTS

10 NAME OF FATHER Thomas Bedford Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) same

12 MAIDEN NAME OF MOTHER Elizabeth Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) same

14 Informant Edith Turner (Address) 1624 St Paul

15 Filed JUN 19 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25 to Jun 18 1927.

that I last saw her alive on Jun 18 1927.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal disease

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis unspecified

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Catonsville Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical under

(Signed) W. Lenhart M. D.

19 (Address) 1430 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Centreville, Md — DATE OF BURIAL: 6/20 1927

20 UNDERTAKER: H. W. Meade & Son — ADDRESS: 705 N Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23224

CERTIFICATE OF DEATH.

Harford Rd. 77-4489

E 23224

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 St. Helens Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Rolfes

(a) RESIDENCE NO. 3 St. Helens Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine W. Rolfes

6 DATE OF BIRTH (month, day, and year) Nov 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	6 7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John H. Rolfes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catherine Rolfes

(Address) 3 St. Helens Ave

15 Filed 6, 19 C. HAMPSON JONES, M. D.

Per , Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure (Myocardial)

(History Angina Pectoris)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. H. Cain M. D.

(Coroner)

6/10/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery Date of Burial June 20 1927

20 UNDERTAKER Lilly + Zeiler ADDRESS 1038 N. Wolfe St

If death occurred in part thereof, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23225

CERTIFICATE OF DEATH.

183

E 23225

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Grosse

(a) RESIDENCE NO. 257 McCurley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) June 29th 1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER John Grosse

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Wunder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant John Grosse

(Address) 257 McCurley St

15 Filed ....., 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 17th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained I find that said deceased came to h... death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Accidentally shot in head (duration) 10 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

June 17th 1927 (Signed) Thos. B. Horton M. D. (Coroner) (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial June 18 1927

20 UNDERTAKER F. A. Wippert ADDRESS 150 Holden St

very important. See instructions on back of certificate. OCCUPATION IS

Spec.—1-12-23—M&T—500 Blks.

E 23226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. 23226

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 129 S. Eutaw St. (WARD) 20th

2-FULL NAME Augusta Baier

(a) RESIDENCE No. 129 S. Eutaw St. ST., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Baier

6 DATE OF BIRTH (month, day, and year): May 22-1868

7 AGE: Years 59 | Months — | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: [illegible] Burnbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Geo. Baier 129 S. Eutaw St

15 Filed JUN 19 1927 Registrar HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/17 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3- , 1927, to June 17 , 1927.

that I last saw h alive on June 16 , 1927.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Hypertension

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam Angina Pain

(Signed) Chas A Reim, M. D.

6/18, 1927 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: June 21st 1927

20 UNDERTAKER: E. R. Weyforth

ADDRESS: 1850 N. Baker St

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23227

CERTIFICATE OF DEATH.

90 ✓ E 23227

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2313 N. Calvert St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Caskie

(a) RESIDENCE NO. 2313 N. Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ widower

6 DATE OF BIRTH (month, day, and year) Feb. 9 1840

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	87	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Druggist

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va.

PARENTS

10 NAME OF FATHER James Caskie

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Miss Randolph

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Clarence Caskie

(Address) 2313 N. Calvert St

15 Filed ..... 19..... C. HARRISON JONES, M. D. Registrar

JUN 19 1927

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17

I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 18, 1927, that I last saw h.. alive on June 17, 1927, and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis

(Always well till June 1, 1927)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Artery disease

Anginal attacks (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) Frank R. Smith, M. D.

18, 1927 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Remington Va Date of Burial 6/20 1927

20 UNDERTAKER Mary M. Wedefield ADDRESS 501 E 22nd

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23228

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23228

CERTIFICATE OF DEATH.

175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1723 Madison ave (St.) 7-13 (Ward)

2-FULL NAME William R. Reid

(a) RESIDENCE. (No.) 1723 Madison ave (St.) (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Reid

6 DATE OF BIRTH (month, day, and year): 7-16-870

7 AGE: 57 Years; 11 Months; Days; If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Janitor

(c) Name of employer: Janitor

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Dyer Major (Address) 1723 Madison Ave

15 Filed JUN 17 1927 C. HAMPSON JONES, M. D. Registrar Per R.E.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16 1927 to June 16 1927

that I last saw him alive on June 16 1927

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Coleman, M. D.

June 17. 1927 (Address) 2039 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: June 6 1927

20 UNDERTAKER: George I. A. Gilson ADDRESS: 1635 Druid Hill Ave

Instructions for filling out the various items will be found on the back of this certificate. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23229

CERTIFICATE OF DEATH.

E 23229

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kelly

(a) RESIDENCE NO. 1008 S.W. 3rd Ave Miami Fla Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17/1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Miami, Fla

PARENTS

10 NAME OF FATHER Chas.A. Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N.J.

12 MAIDEN NAME OF MOTHER Maggie Atrice

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mexico.

14 Informant Chas. A. Kelly

(Address) Miami, Fla.

15 Filed 19 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 18/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hydocephalus- Brain Tumor (

(Autopsy at Hopkins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

6/18/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Miami Fla — Date of Burial 6/19/27

20 UNDERTAKER Joseph Ahern — ADDRESS 771 Bway

Or DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Suit.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 3629 E 23230 — 159-001 ×

REGISTERED NO. E 23230

1-PLACE OF DEATH: City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 17-26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Linkin

(a) RESIDENCE NO. 518 Pine St. St. Ward Louisville Ky.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-14-27

7 AGE: Years — Months: 5 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): nil

(c) Name of employer

9 BIRTHPLACE (city or town): Ky —

(State or country)

PARENTS

10 NAME OF FATHER Clarence Linkin

11 BIRTHPLACE OF FATHER (city or town): Ky —

(State or country)

12 MAIDEN NAME OF MOTHER Helen Sayes

13 BIRTHPLACE OF MOTHER (city or town): Ky —

(State or country)

14 Informant: Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 5 1927 WM. H. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to June 18, 1927, that I last saw him alive on June 18, 1927, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus. (Communicating)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) from birth. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/5/27

Was there an autopsy? yes

What test confirmed diagnosis? Operation & autopsy

(Signed) George S. Finney, M.D.

6/18/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louisville Ky — Date of Burial: 6/19/27

20 UNDERTAKER: D. Joseph Ahrens — ADDRESS: 221 Knowles

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. If the space provided for any item is not sufficient, use the reverse side. Answer all questions in full terms, so that it may be properly classified.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23231

CERTIFICATE OF DEATH.

161-002

E 23231

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 27-46 Ward)

2-FULL NAME Baby Charles

(a) RESIDENCE NO. 5920 Bellona ave St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or 30 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Johns Hopkins Hospital

(State or country) ....

PARENTS

10 NAME OF FATHER Carl Charles

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Hattie Resmo

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Pa.

14 Informant Records.

(Address) Johns Hopkins Hospital

Filed JUN 20 1927 19 C. HAMPSON JONES, M. D. Registrar.

Per RRC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to June 18, 1927,

that I last saw h.~~im~~ alive on June 18, 1927,

and that death occurred, on the date stated above, at 11:15 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia pallida.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Prolonged dry labor

Excessively long umbilical cord.

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Yes Date of 6/18/27.

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Presbyterian Loans	6/20 1927
20 UNDERTAKER	ADDRESS
Wm Cook	501 E Mad St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E. 23232

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 23232

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 17-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Lee

(a) RESIDENCE NO. 6 Gist Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2mos. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxxxx unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr. Gibson

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Moses Liven

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Susan Gassan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Emma Cotton

(Address) 552 W. Lanvale St

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

RKK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Autopsy at Hopkins

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - Arterio-sclerosis (duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

(Coroner)

6/19/27, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Senor, Va Lancaster Co Date of Burial Jun 19 1927

20 UNDERTAKER John H Toadvine ADDRESS Mt. Hall

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23233

CERTIFICATE OF DEATH.

90 E 23233

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3345 Chestnut Ave ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rebecca Catherine Wink.

(a) RESIDENCE NO. 3345 Chestnut Ave, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Single

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~: maiden

6 DATE OF BIRTH (month, day, and year) Dec 13-1848

7 AGE: 78

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Wink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Beckleysville Balto. Co.

12 MAIDEN NAME OF MOTHER: Margaret Willeben

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Beckleysville Balto. Co.

14 Informant (Address): Walter E. Willeben 3345 Chestnut Ave.

15 Filed JUN 20 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RKL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15 , 1927 , to June 17 , 1927 , that I last saw ~~her~~ alive on June 16 , 1927 , and that death occurred, on the date stated above, at 8-15A m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

& Cardiac insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

19 (Address) 5429 Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester, Carroll Co.

DATE OF BURIAL: June 20, 1927

20 UNDERTAKER: E. Leroy Stiffler

ADDRESS: 125 E. North Ave.

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2037 63 E 23234 — 24 E 23234

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Nemec

(a) RESIDENCE NO. 205 N. Curley St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 23, 1907

7 AGE: Years — Months — Days 24 34 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Nemec

11 BIRTHPLACE OF FATHER (city or town) Czecho

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Czecho

(State or country)

14 Informant Parent

(Address) JOHNS HOPKINS HOSPITAL

Filed June 29 1927 H. A. Williamson M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927 to June 19, 1927, that I last saw him alive on June 19, 1927 and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcus)

(duration) .....yrs. .....mos. 40 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Spinal fluid Culture

(Signed) H. G. Hambley, M. D.

, 19 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial June 21 1927

20 UNDERTAKER: Edward H. Conklin ADDRESS 924 E. Eager St.

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spoc.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23235

CERTIFICATE OF DEATH

43 E 23235

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2236 Barclay St. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph William Parke

(a) RESIDENCE NO. 2236 Barclay St St. 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 50 yrs. 8 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): October 26 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	50	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst. Treasurer.

(b) General nature of industry, business, or establishment in which employed (or employer): Auditorium

(c) Name of employer: Theatre

9 BIRTHPLACE (city or town): Westminster

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Fleming Parke

11 BIRTHPLACE OF FATHER (City or town): Westminster

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Alberta Grumbine

13 BIRTHPLACE OF MOTHER (city or town): Westminster

(State or country): Md.

14 Informant: Mrs. Adah Seymour (Friend)

(Address): 2236 Barclay St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUN 20 1927

Per RKE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1926 to June 18 1927.

that I last saw him alive on June 18 1927.

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. 9 mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Microscopical Exam

(Signed) R. L. Taylor M. D.

19 (Address) Westminster Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster - Md.

Date of Burial: June 21 1927

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23236 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. St.) 15-65 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyers Marks

(a) RESIDENCE NO. 1910 Linden Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: William Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Goorfoody

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): West Baltimore Gen. Hosp Roads.

15 Filed NOV 23 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/8, 1927, to 6/19, 1927, that I last saw h[e] alive on 6/19, 1927, and that death occurred, on the date stated above, at 10-45 a m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Post operative pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6/9/27

Was there an autopsy? no

What test confirmed diagnosis? Gross & Histology

(Signed) Arnold L. Jensen M. D.

6/19, 1927 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nelson Rosedale

DATE OF BURIAL: 6/20 1927

20 UNDERTAKER: Jack Louis

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23237
1-PLACE OF DEATH

1794

REGISTERED NO. E 23237

City of BALTIMORE: (No. South Baltimore General Hospital 2681

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norma Koran.

(a) RESIDENCE NO. 602 N. Clinton, St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----; ----

6 DATE OF BIRTH (month, day, and year) July 11, 1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Koran.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Antonia Minarik.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia.

14 Informant Antonia Koran. (mother)

(Address) 602 N. Clinton St.

15 Filed. JUN 20 1927 C. HAMILTON JONES, M. D. Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scalds about the back, body and buttocks Accicental fall into a bucket of hot water.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto R. Reinhardt M. D.
(Coroner)

6/18 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
602 N. Clingon St. June 17, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial: June 20 1927

20 UNDERTAKER: Funk Eutaw Sol — ADDRESS: 190 Ashland

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23238

CERTIFICATE OF DEATH

155 E 23238

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 8-16 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Lacey —

(a) RESIDENCE NO. 1933 N. Eutaw Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 9 25

7 AGE: Years 1 Months 20 Days 10 IF LESS than 1 day hrs. or min.. 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John G. Lacey. Sr.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Gertrude Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John G. Lacey, Sr. (Address) 1933 N Eutaw Ave

15 Filed JUN 20 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1927

17 I HEREBY CERTIFY, That I attended deceased from April 26. 1927. to June 19. 1927.

that I last saw h in alive on June 19. 1927.

and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lupus Erythematosus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/4/27

Was there an autopsy? Yes 5/19/27

What test confirmed diagnosis?

(Signed) D. Gurth, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dell Lawn Cem — Date of Burial: June 21 1927

20 UNDERTAKER: Geo M. Frick & Son — ADDRESS: 811 N. Howard

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20398 E 23239

9 ✓

REGISTERED NO. E 23239

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Collicin

(a) RESIDENCE NO. 1101 Wilcox St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 4-19-27

7 AGE: Years — Months 2 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER Roland Collicin

11 BIRTHPLACE OF FATHER (city or town): Md —

(State or country)

12 MAIDEN NAME OF MOTHER Anne Akers

13 BIRTHPLACE OF MOTHER (city or town): Md —

(State or country)

14 Informant: Records —

(Address) JOHNS HOPKINS HOSP

15 Filed JUN 20 1927 Per L.H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1927

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 18, 1927, that I last saw h.r. alive on June 18, 1927, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Whooping cough, pneumonia, enlarged ~~thymus~~ thymus.

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home 1101 Wilcox St

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? post-mortem exam

(Signed) H. E. Harding, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catheridal — Date of Burial June 20th 27

20 UNDERTAKER: Leo. G. Cook — ADDRESS 1723 Patterson Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23240

CERTIFICATE OF DEATH.

E 23240

1-PLACE OF DEATH

City of BALTIMORE: (No. 2825 Woodbrook Ave. 13-59 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hedwig H. Hachtel

(a) RESIDENCE NO. 2825 Woodbrook Ave. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. — mos. — ds. (If non-resident give city or town and State) —How long in U. S., if of foreign birth? 86 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Hachtel

6 DATE OF BIRTH (month, day, and year) June 8-1839

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	88	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Christian H. Zeller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Cann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Grace T. Hachtel

(Address) 2825 Woodbrook Ave

15 Filed _____, 19 _____ C. HAMPSON JONES, M.D. Registrar

NOV 20 1927 RJL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17

I HEREBY CERTIFY, That I attended deceased from June 2 1927, to June 19, 1927, that I last saw h. alive on June 18, 1927, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ____ yrs. ____ mos. 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B Lemmon, M. D.

, 19 (Address) 2516 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial June 22 1927

20 UNDERTAKER Harry W. Ellen ADDRESS 1944 W. Northern

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23241

CERTIFICATE OF DEATH

75-001 E 23241

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 5? Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE NO. 1409 Matthews St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Annie ——

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) Records

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

N 20 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to June 17, 1927, that I last saw him alive on June 16, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

Residual left Hemiplegia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hobart Smith M. D.

June 19 1927 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Asbury Cem	6-20 1927

20 UNDERTAKER ADDRESS

pas. Inst Skinner 1620 E. Pratt

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23242

CERTIFICATE OF DEATH.

101-001

E 23242

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. J-4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kasper Juchno

(a) RESIDENCE NO. 1916 Alice Anna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Juchno,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria,

PARENTS

10 NAME OF FATHER Joseph Juchno,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria,

12 MAIDEN NAME OF MOTHER Sophia *******

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria.

14 Informant Guok Bzko

(Address) 1916 Alicesanna Street

15 Filed JUN 20 1927 C. HAMPTON CONNER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

June 19 27 (Signed) H. C. Blake M. D.

(Coroner)

(Address) 143 N. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
ST. STANISLAUS CEMETERY	June 21 1927.
20 UNDERTAKER M. F. Sadowski	ADDRESS 705 S. Ann St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 23243

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 23243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Linwood ST., 6-11 WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Cooney

(a) RESIDENCE NO. 21 N. Linwood ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Patrick J. Cooney

6 DATE OF BIRTH (month, day, and year) July 12th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Michael Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Nihill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daniel J. Cooney

(Address) 21 N. Linwood ave

15 Filed 6-20-1927 J. HAMPTON JONES, M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927 to June 17 1927

that I last saw her alive on June 17 1927

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Intermediate Pulmonary Oedema

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Uremia Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) P. Field M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL June 21st 1927

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2818 E Baltimore St

THIS IS very important. See instructions on back of certificates.

Hood. 626 N. Gilmor

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23244

CERTIFICATE OF DEATH

129 E 23244

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2556 Ravner Av St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Victoria Lewis

(a) RESIDENCE NO. 2556 Ravner Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles T Lewis

6 DATE OF BIRTH (month, day, and year): Jan 28 1843

7 AGE: Years 84 Months 5 Days 20 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER John Jacobs

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Mrs. K Jones

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs. J. Hamill

(Address) 2556 Ravner Av

15 Filed JUN 20 1927 C. HAMPSON JONES, M. D. Registrar

Ref. RJL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to June 18, 1927,

that I last saw her alive on June 16, 1927,

and that death occurred, on the date stated above, at 5-30 m.

The CAUSE OF DEATH* was as follows:

(a)

(b) Chronic interstitial Nephritis

(duration) yrs. 6 mos 6 ds.

CONTRIBUTORY (Secondary) Asthma - Edema.

(duration) 3 or 4 yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bauman Hood M. D.

6/20, 1927 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park June 20 1927

20 UNDERTAKER: H. W. Cole ADDRESS 512 E. Fayette

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23245

CERTIFICATE OF DEATH

49 E 23245

E-23245
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 17-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Mr.) ANDREW KENNEDY

(a) RESIDENCE NO. 218 Homewood Terrace Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Kennedy

6 DATE OF BIRTH (month, day, and year): Feb 14 - 1840

7 AGE: Years 87 Months 4 Days 4 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Kennedy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Kennedy

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

14 Informant: Dr Wm A. Kennedy

(Address) 218 Homewood Terrace

15 Filed JUN 20 1927 H. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 18 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 27 to June 18, 19 27, that I last saw h. alive on June 18, 19 27, and that death occurred, on the date stated above, at 6 30/P m.

The CAUSE OF DEATH* was as follows:

Malignancy of urinary bladder

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hx

(Signed) J. Marcus, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 6/21 27

20 UNDERTAKER: Chas P. Kraus & Son — ADDRESS 1818 Mt Royal Ave

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23246

CERTIFICATE OF DEATH

113 E 23246

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 5 Altoona Ave St. 7-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard J. Bittner

(a) RESIDENCE NO. 5 Altoona Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. if of foreign birth? yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 25 - 1926

7 AGE — Years: — Months: 8 Days: 24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Richard J. Bittner

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country):

12 MAIDEN NAME OF MOTHER: Madeline Mayd

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country):

14 Informant: Richard J. Bittner

(Address): 5 Altoona Ave

15—Filed ....., 19..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 27, to June 18, 19 27,

that I last saw h~~er~~ alive on June 18 19 27,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Acute Hem. Nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Acidosis

(duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Simon M. D.

6/18 19 27 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orkney Cemetery — Date of Burial: June 20 1927

20 UNDERTAKER: Chas. S. Manes & Son — ADDRESS: 1182 Edmondson Ave

JUL 20 1927 C. HAMPSON JONES, M. D.

If Death is from any Violent Cause, or Suspicious, Fill Out Other Side.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23247

CERTIFICATE OF DEATH.

E 23247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Longston St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Lipp

(a) RESIDENCE NO. 1424 Longston ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E. Lipp

6 DATE OF BIRTH (month, day, and year) May 21-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Lipp (Address) 1424 Longston

15 Filed Jun 29 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to June 18, 1927, that I last saw h alive on June 18, 1927 and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

(a) Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. [illegible] M. D.

6/21 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet.

DATE OF BURIAL 6/21 1927

20 UNDERTAKER J. F. McCully

ADDRESS 130 E. Fay

Spec.-7-17-26—A Co.—200 Bks.

E 23248

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23248

31

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Agnes Hospital — REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Washington

(a) RESIDENCE NO. St Paul's Rectory Caroline & Oliver St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1870

7 AGE: Years 57 Months Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook. 071

(b) General nature of industry, business, or establishment in which employed (or employer): St Pauls. Rectory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Isaac Mack

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Kate Washington (Address): St Paul Rectory

15 Filed JUN 20 1927 G. HAMPSON JONES, M. D. Registrar Per R.H.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June. 19- 27

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to June. 19, 1927, that I last saw her alive on June 19, 1927, and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Ulc. Alveolar Pulmonary TB.
Chr. Myocarditis Chr regurgitation.
Pleurisy with Effusion.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) yrs. mos 8 ds.

18 Where was disease contracted: at home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Fossas, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — Date of Burial: June 23 1927

20 UNDERTAKER: Mrs. R.G. Elliott — ADDRESS: 1225 Eutaw

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 23249 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23249

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1420 E. Monument ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Chaney

(a) RESIDENCE NO. 1420 E Monument ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reginald Chaney Lieutenant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	30	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. Burgin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Lucas

(Address) 1420 E Monument St

15 Filed ..... 19 .....

C. HAMPSON BOOKS, M. D.

Registrar

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/1927

17 I HEREBY CERTIFY, That I attended deceased from 6/18/1927, to 6/19/1927, that I last saw h[illegible] alive on 6/19/1927 and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmahage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cut[illegible] Pneumonia

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Jno Gowley M. D.

(Address) 908 Shot St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 27

20 UNDERTAKER Mrs Ida Saunders — ADDRESS 1725 Ashland Ave

Spec.–7-17-26–A Co.–200 Bks.

Royal

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23250

CERTIFICATE OF DEATH

129 E 23250

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

City of BALTIMORE: (No. 25-76 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Royal

(a) RESIDENCE NO. 5-11 St. Fairfield – Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: Years 57 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartsdaleville Ga

(State or country)

PARENTS

10 NAME OF FATHER Prince Royal

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Mississippi

12 MAIDEN NAME OF MOTHER Clara Washington

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Macon Georgia

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed JUN 20 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to June 17, 1927, that I last saw him alive on June 17, 1927, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Interstitial Nephritis

(duration) yrs. ? mos. ds.

CONTRIBUTORY Acute Nephritis

(Secondary)

(duration) yrs. mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? General & Laboratory

(Signed) C R Hooper Lunt M. D.

June 18 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Plant City Fla — Date of Burial: June 21 1927

20 UNDERTAKER: Robert E. Wilson — ADDRESS: 1515 McElderry St

very important. See instructions on back of certificates.

Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

E 23251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 E 23251

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. N. Broadway, Balt. St. 42-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Gerczak (Gutz)

(a) RESIDENCE NO. 2026 Fleet St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): unknown 1870

7 AGE — Years: 57 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Wladislaw Gerczak Gutz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Joseph Gerczak (Son)

(Address) 2026 Fleet St

15 Filed JUN 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 6-15-27 to 6-18-, 1927, that I last saw him alive on 6-18-, 1927, and that death occurred, on the date stated above, at 3:35 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Myocarditis, Chr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 6-15-27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. McCrea, M. D.

19 (Address) Church Home Clinic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial June 21 1927

20 UNDERTAKER: F. W. Ozazewski ADDRESS 1930 Eastern Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 23252

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 20-10 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Smith

(a) RESIDENCE NO. 502 Tennessee St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-18-27

7 AGE — Years: 0 — Months: 0 — Days: 1 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Sydney Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mabel Fretz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Father

(Address) 502 Tennessee St

15 Filed ..... 19 .....

JUN 20 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1927, to June 18, 1927.

that I last saw h— alive on June 18, 1927.

and that death occurred, on the date stated above, at 7:04 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

7 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not nt place of death?

Did an operatinn precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones

. 19 (Address) Mercy Hospital, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial 6-20 1927

20 UNDERTAKER E T B Harle — ADDRESS 115 E Mulberry St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23253

CERTIFICATE OF DEATH

90

E 23253

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3405 Greenway (S.) 12-49 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Mrs) Katherine M. Duvall

(a) RESIDENCE No. 3405 Greenway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 5 mos. 10 dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: S. Turner Duvall Widow

6 DATE OF BIRTH (month, day, and year): Jan 9th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: J. L. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md.

12 MAIDEN NAME OF MOTHER: Hannah E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co. Md.

14 Informant: Baedyn. Godwin

(Address) 3405 Greenway.

15 Filed JUN 20 1927 By R.H. Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 — 19 — 1927.

17 I HEREBY CERTIFY, That I attended deceased from 1 — 5, 1927, to 6 — 18, 1927, that I last saw her alive on 6 — 18, 1927 and that death occurred, on the date stated above, at 6-19-27 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Hypertension.
Arteriosclerosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Waddy, M. D.

(Address) 1403 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: June 21 1927

20 UNDERTAKER: Henry Graham Sons

ADDRESS: McCulloh & Orchard Sts.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23254

CERTIFICATE OF DEATH.

1488-003 V

E 23254
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No.) Franklin Sq. Hosp St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Johnson

(a) RESIDENCE NO. 1153 N. Mount St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: Col'd
5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23rd 1914

7 AGE: Years 13 Months — Days 2

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER James H. Johnson
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va
12 MAIDEN NAME OF MOTHER Annie Moore
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant James H. Johnson
(Address) 1153 N. Mount St

15 Filed JUN 20 1927 Per C. HAMILTON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Fract R. Clavicle
(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary) Accidentally Struck by Auto
(duration) yrs. mos. ds.
June 20, 1927 (Signed) Thos. B. Horton M. D.
(Coroner)
(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial June 20 27

20 UNDERTAKER James O'Hensley ADDRESS 578 N. Gilmor St

Very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23255 ✓

E 23255
1-PLACE OF DEATH

REGISTERED NO. X 129

City of BALTIMORE: (No. Provident Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Carey

(a) RESIDENCE NO. 107 Winters ave Catonsville St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Jan~~ 1862

7 AGE Years: about 65 Months: Days: IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 08

(c) Name of employer

9 BIRTHPLACE (city or town): unknown
(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): unknown

14 Informant: hospital record
(Address)

15 Filed ....., 19..... C. HAMPSON JONES, M. D.
Registrar

JUN 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 1927, to 6-16, 1927,
that I last saw h[illegible] alive on 6-16, 1927,
and that death occurred, on the date stated above, at 3:00 p.m.
The CAUSE OF DEATH* was as follows:

Uraemic poisoning

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Catonsville md
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Thomas J. Lansdale, M. D.
, 19 (Address) 1029 N Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Star	6/21 1927
20 UNDERTAKER: Thomas J. Hensley	ADDRESS 1078 Madison

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23256 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23256

CERTIFICATE OF DEATH.

94-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Moore St. 11-24 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Cornish

(a) RESIDENCE. No. 426 Moore St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Walter Evans
(Address): 627 N Paca St

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

JUN 20 1927

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 17, 1927, that I last saw h alive on June 17, 1927, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Rt. side hemiplegia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. J. Keller, M. D.

6/19, 1927 (Address) 722 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 20 1927

20 UNDERTAKER: Samuel J. Stanley ADDRESS 573 Bel Air

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23257

CERTIFICATE OF DEATH

90 E 23257

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 14-27

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Keys

(a) RESIDENCE NO. 122 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Keys

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 44 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Tobe Keys

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) [illegible] Woods

15 Filed , 19

Registrar

JUN 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 17, 1927, that I last saw h[illegible] alive on June 17, 1927, and that death occurred, on the date stated above, at 12.35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Emphysema

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & laboratory

(Signed) R. Hooper Smith M. D.

June 18 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial 6/20 1927

20 UNDERTAKER: Emmett F. Handley ADDRESS [illegible] Waddell

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23258

CERTIFICATE OF DEATH.

E 23258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Boulevard Apts St Paul & 32nd St. (Ward) 12-50

2-FULL NAME William Albert Brown

(a) RESIDENCE NO. St Paul & 32nd St., Ward New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniella Laura Brown

6 DATE OF BIRTH (month, day, and year): Dec. 20, 1857

7 AGE: Years 69 | Months 5 | Days 28 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Publisher

(b) General nature of industry, business, or establishment in which employed (or employer): 056

(c) Name of employer: Wm. A. Brown

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Mr. Harold Brown

(Address) St Paul & 32nd Sts. Boulevard apts.

15 Filed JUN 20 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4 27 to June 18, 1927, that I last saw him alive on June 17, 1927, and that death occurred, on the date stated above, at 2.20 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) One yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? New York N.Y.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/19, 1927 (Address) 320 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: June 20 1927

20 UNDERTAKER: Wm J Tucker & Sons

ADDRESS: North Pa

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23259

CERTIFICATE OF DEATH.

185 ✓ E 23259

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1702 Ramsay St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria W. Carneal

(a) RESIDENCE NO. 1702 Ramsay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Wid.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/15/42

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
8.4	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Jas. Thomas

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant W. L. Rume

(Address) 1702 Ramsay St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUN 28 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/20/27, 19..., to 6/19/27, 19...,

that I last saw h... alive on 6/19/27, 19...,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Hypostasis

Ether Inst. Syph.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fracture Hip & Broken Leg. Accidental fall

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard J. Levy, M. D.

6/19/1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tabbahannock Va Date of Burial June 21 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

23260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23260

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3436 Auchentoroly Ter Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Z. Lazaron.

(a) RESIDENCE (No.) 3436 Auchentoroly Ter Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel L. Lazaron

6 DATE OF BIRTH (month, day, and year): March 29, 1859

7 AGE: Years 68 Months 2 Days 20

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Orleans

(State or country) La.

PARENTS

10 NAME OF FATHER Jacob Osorio de Castro

11 BIRTHPLACE OF FATHER (City or town)

(State or country) St. Thomas, Virgin I.

12 MAIDEN NAME OF MOTHER Hannah de Sola

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St. Croix, Virgin I.

14 Informant (Address) Morris S. Lazaron 1415 Madison ave.

15 Filed JUN 20 1927 19

C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I attended deceased from December 6 1927, to June 19, 1927,

that I last saw her alive on June 18, 1927,

and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of December 6-1926

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Charles H. Hessman, M. D.

19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew cem

Date of Burial: 6/21 1927

20 UNDERTAKER: J. Ahrens & Co

ADDRESS: 2432 Reisterstown Rd

E 23260 IS THE NUMBER TO BE USED IN REFERRING TO THIS CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23261

CERTIFICATE OF DEATH.

199 E 23261

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 9-46 Ward)

2-FULL NAME Mrs. Mildred Maine

(a) RESIDENCE NO. 300 E. 31st St City St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Walter Maine

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 28 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Rock Hall

(State or country): Md

PARENTS

10 NAME OF FATHER: John Hyland

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Kent Co Md.

12 MAIDEN NAME OF MOTHER: Margaret Van Gant

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Kent Co Md.

14 Informant: Walter L. Maine.

(Address): 66 Mellor Ave Catonsville

15 Filed 1927 19 HAMPSON JONES, M. D.

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-18-1927

17

I HEREBY CERTIFY, That I attended deceased from 2-23 1927, to 6-18, 1927, that I last saw h__ alive on 6-18, 1927 and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Abortion — Self induced followed by Generalized Septicaemia. Ischio rectal abscess.

(duration) ....yrs. 3 mos. 20 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 4-30-27, 5-25-27.

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy, operation & Clinical data

(Signed) A. J. Knapp, M. D.

6-18, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wesley Chapel Cem Rock Hall Md Date of Burial: June 22 1927

20 UNDERTAKER: Harry A Armacost ADDRESS: 4204 Ridgewood Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—300 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23262

CERTIFICATE OF DEATH.

90 E 23262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 S. Calhoun ST. 14-29 WARD)

2-FULL NAME William Thomas Russell

(a) RESIDENCE NO. 347 S. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	7	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William C. Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Rose L. Drexel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Wm C Russell (Address) 347 S. Calhoun St

15 Filed JUN 20 1927 19 Per [illegible] Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 19 24, to June 18, 19 27, that I last saw him alive on June 18, 19 27, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocorditis (Rheumatic)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Oliver Culver M. D.

6/20, 1927 (Address) 711 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 6-21-27.

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 Pine St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23263

CERTIFICATE OF DEATH

91-02

E 23263

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 E 23rd St. St., 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carol Ellen Puttle.

(a) RESIDENCE NO. 717 E 23rd St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Puttle

6 DATE OF BIRTH (month, day, and year): June 29th 1856

7 AGE: Years 70 Months 11 Days 18 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of indostry, business, or establishment in which employed (or employer): "

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) Cambridge (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H. Grace

11 BIRTHPLACE OF FATHER (City or town) Easton (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna M. Cook

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Md.

14 Informant Mrs. F. Emmert apt (Address) 717 E 23rd St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.D.

JUN 20 1927

Per R.M.S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1927, to June 18th, 1927, that I last saw her alive on June 18th, 1927, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Anemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W Kyle, M.D.

6/18/27 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial 6/20/1927

20 UNDERTAKER: Earl A Farley ADDRESS: Fulton & Fayette

very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

E 23264

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23264

CERTIFICATE OF DEATH.

20-69 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S. Smallwood ST.) (WARD)

2-FULL NAME Edwin L. Kennedy

(a) RESIDENCE No. 321 S. Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Madyland

PARENTS

10 NAME OF FATHER Wm. Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 18, 1927,

that I last saw h alive on June 15, 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Hamburger, M. D.

, 19 (Address) 1414 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Mrs Sarah Kennedy 321 S Smallwood

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 6/21/1927

19 UNDERTAKER George & Stanley Scullin ADDRESS Fayette

JUN 20 1927 C. HAMPSON JONES, M. D.

Registrar

Per

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23265

CERTIFICATE OF DEATH.

E 23265

REGISTERED NO. 1731 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Henrietta ST. 1731 WARD)

2-FULL NAME Henrietta Ford

(a) RESIDENCE NO. 117 Henrietta ST., 22 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of: Zillie Ford

6 DATE OF BIRTH (month, day, and year): Sept 28, 1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
27	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): House wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Hampton Co, Va

PARENTS

10 NAME OF FATHER: Robert Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brunswick Co. Va.

12 MAIDEN NAME OF MOTHER: Fannie Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Smithfield Hampton Va.

14 Informant (Address): Zellie Ford. 117 W Henrietta St

15 Filed JUN 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/19/1927

17 I HEREBY CERTIFY, That I attended deceased from 6/19/1927 to 6/19/1927 that I last saw her alive on 6/19/1927 and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Tympany, Acute Dilatation of Cardiac; and Hypostasis

(duration) yrs. mos 6 hrs

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physicals & History

(Signed) J. W. Bishop, M. D.

, 19 (Address) 709 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Capron Va — DATE OF BURIAL: June 21 1927

20 UNDERTAKER: Ernest Lee — ADDRESS: 604 N Fremont

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23266

CERTIFICATE OF DEATH.

129 E 23266

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hosp. St., 7-11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Myrtle Poole

(a) RESIDENCE NO. 523 N. Ellwood Ave St._____ Ward._____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry P. Poole

6 DATE OF BIRTH (month, day, and year): Sept 12 1891

7 AGE: Years 35 | Months 9 | Days 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 3/

(c) Name of employer: 0

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Wm T. Stansbury

11 BIRTHPLACE OF FATHER (city or town): Balto Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary E. Tyson

13 BIRTHPLACE OF MOTHER (city or town): Balto Md.

(State or country)

14 Informant (daughter) Myrtle Poole

(Address) 523 N Ellwood ave

Filed C. HAMPSON JONES, M. D.

JUN 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-3, 1927, to 6-18, 1927, that I last saw her alive on 6-18, 1927, and that death occurred, on the date stated above, at 7 10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Myocardial insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Uremia

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Knapp, M. D.

6-18, 1927 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial 6 22 1927

20 UNDERTAKER: Philip Henry ADDRESS 204 Columbia

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23267 ✓ E 23267

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N Bond ST. 6-9 WARD)

2-FULL NAME Joseph Parker

(a) RESIDENCE NO. 107 N Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0+0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Alex Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Ingrid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louise Parker (sister)

(Address) 1324 N Bond st

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927, to June 19, 1927, that I last saw him alive on June 18, 1927, and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess (acute)

(duration) yrs. 3 wks ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. H. Jones, M. D.

6/20, 1927 (Address) 1324 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 6-21 1927

20 UNDERTAKER Jas. M. Skinner — ADDRESS 1625 E. Monument st

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23268

CERTIFICATE OF DEATH

X 44 E 23268

1-PLACE OF DEATH

REGISTERED NO. 1421

City of BALTIMORE: (No. Maryland General Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Clifford Janney

(a) RESIDENCE NO. Edgewood Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-18-1857

7 AGE: Years 70 Months 1 Days 2 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cecil Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Janney

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachel Slade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Record (Address)

15 Filed JUN 20 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-20-27

17 I HEREBY CERTIFY, That I attended deceased from 6-16-27, 19, to 6-20-27, 19,

that I last saw him alive on 6-20, 1927,

and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Pylorus and Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diarrhea

(duration) 0 yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Johnson, M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnson Dening — Date of Burial: June 20 1927

20 UNDERTAKER: Bay View — ADDRESS: Cecil Co. Md. 715 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

See Letter on file dated Aug 8-1928

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23269

CERTIFICATE OF DEATH.

X 52 E 23269

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Holden ST., 430 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Mooney

(a) RESIDENCE NO. Monkton Md ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 5. 1911

7 AGE — Years: 15 — Months: 10 — Days: 13 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: High School

(b) General nature of industry, business, or establishment in which employed (or employer): Student

(c) Name of employer: —

PARENTS

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

10 NAME OF FATHER: John J Holden ~~Elmer Mooney~~

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn N.Y. ~~Pa~~

12 MAIDEN NAME OF MOTHER: Mabel Dayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y

14 Informant: Mabel Mooney
(Address): Monkton Md

15 Filed ... 19 ... Registrar: C. HAMPSON JONES, M. D.

2 0 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1926 to June 18 1927, that I last saw h er alive on June 18 1927, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio Vascular Disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? ~~Autopsy~~ Autopsy & Testing

(Signed) H. E. Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 21 1927

20 UNDERTAKER: Mrs. John W. Pinkett & Son — ADDRESS: 201 W Fayette

Spec.—1-12-23—M&T—500 Bks.

E 23270

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23270

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. High Street ST., 5-8 WARD)

2-FULL NAME Abraham Feinstein

(a) RESIDENCE NO. 11 N High Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jack Feinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dintsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis (Address) 1439 E Baltimore St

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/1927

17 I HEREBY CERTIFY, That I attended deceased from August, 1924, to June 20, 1927, that I last saw h alive on June 17, 27, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (over)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Norfolk

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? cystoscopic exam.

(Signed) G. C. Hampson Jones M. D.

, 19 (Address) Emmitsburg Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herren Run — DATE OF BURIAL 6/21/1927

20 UNDERTAKER Jack Levis — ADDRESS 1439 E Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23271

CERTIFICATE OF DEATH.

101-001 ✓ E 23271

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 Prestman St. 15-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Young

(a) RESIDENCE NO. 1317 Prestman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Allen Young

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 10 0

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Harrison Hill

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Clara Young

(Address) 1317 Prestman

15 Filed ..... 19 ..... Registrar

0 1927 C. HAMPSON JONES, M. D.

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1927, to June 19, 1927,

that I last saw h[illegible] alive on June 18, 1927,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Fabricin Heart Disease

(duration) ..... 1 yrs.? ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cornelius Trey, M. D.

6/19, 1927 (Address) 1908 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 6/23/1927

20 UNDERTAKER Chas. Alexander — ADDRESS 1408 Druid Hill Ave

Very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

E 23272

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23272

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Oakley St. ST., 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Roth.

(a) RESIDENCE NO. 1808 Oakley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lily May Roth.

6 DATE OF BIRTH (month, day, and year) Feb. 24-1866

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	61	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant-

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper, 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER George Henry Roth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Lamp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Lily May Roth.

(Address) 1808 Oakley St.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-17th-1927.

17 I HEREBY CERTIFY, That I attended deceased from June 16. 1927. to June 16. 1927. that I last saw him alive on June 16. 1927., and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Lethbridge M. D.

6/20 1927 (Address) Balto. Genl. Hospital Paca & Lombard Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews Cemetery. DATE OF BURIAL June 21 1927.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

Spec.—1-12-23—M&T—500 Blks.

E 23273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 23273

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 S. Peter St. WARD) 35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarerio Pylee.

(a) RESIDENCE NO. 220 S. Peter ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 17 1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
18.	2	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Errand

(b) General nature of industry, business, or establishment in which employed (or employer) Boy. 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Emagio Pylee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mc Gown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Anthony Pylee

(Address) 220 S. Peter St

15 Filed JUN 20 1927 .19 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov 12. 1926. to June 19. 1927.

that I last saw him alive on . 19

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? — —

What test confirmed diagnosis?

(Signed) Wesley L Kitzhaber M. D.

6-19 1927 (Address) 1058 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL June 9 1927

20 UNDERTAKER Wendel J Hippel ADDRESS 308 N Eden

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23274

CERTIFICATE OF DEATH.

44 E 23274

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 Anthony Ave St. 16-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter F Holden

(a) RESIDENCE NO. 6 Anthony Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ##########

6 DATE OF BIRTH (month, day, and year): ? ? 1857

7 AGE: Years 70 | Months ? | Days ? | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car repairman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Ireland

PARENTS

10 NAME OF FATHER James Holden

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Deveraux

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant Mrs A Mornigstar

(Address) 6 Anthony Ave

15 Filed_____ 19____ C. HAMPSON JONES, M. D.

Registrar

0 1927 Per RCB

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

June 19

17 I HEREBY CERTIFY, That I attended deceased from May 1 19 27 to June 19 19 27,

that I last saw him alive on June 19 19 27,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Fibroid X

(duration) yrs. mos. 3/4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Lehman, M. D.

June 20, 1927 (Address) 718 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem Date of Burial 6/22/27

20 UNDERTAKER: Edward F. Talbot & Sons ADDRESS 1518 Light St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23275

CERTIFICATE OF DEATH

129 E 23275

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hartman

(a) RESIDENCE NO. 1602 Fleet St St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late anna Hartman.

6 DATE OF BIRTH (month, day, and year): May 24th 1874

7 AGE: 53 Years; Months; Days 25 26

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman Penn R.R. 83

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Hartman

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Barbara Lim Kuhler

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Henry E. Hartmann

(Address) 6506 St. Helena Ave.

C. HAMPSON JONES, M. D.

15 Filed JUN 21 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-19-27

17 I HEREBY CERTIFY, That I attended deceased from 6-18-, 1927, to 6-19, 1927, that I last saw him alive on 6-19, 1927, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) B. Lurie M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: June 23 1927

20 UNDERTAKER: Lilly + Zeller ADDRESS: 1038 Hoyt St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

(Anton Tandte)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23276

CERTIFICATE OF DEATH.

E 23276

74-001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

2-FULL NAME Antton Tandte

(a) RESIDENCE NO. Preston & Valley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5th 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Lawrence Tandte

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Catherine "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed JUN 21 1927, 19 C. HAMPSON JONES, M. D. Registrar

By RKR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from (Forenoon) 19___, to ___, 19___,

that I last saw h___ alive on June 19, 1927

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ___ yrs. ___ mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D.

June 20, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Lorraine Park June 21 1927

20 UNDERTAKER — ADDRESS

Rita Wedefeld 914 Greenmount Ave

very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

E 23277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH [redacted] BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-9 E 23277
REGISTERED NO.

2-FULL NAME Joseph Yesajener (George Jelinek)

(a) RESIDENCE NO. 33 Eden St. Curtis Bay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE: Years 77 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labour

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant [redacted] BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed JUN 27 1927 C. HAMPSON JONES M.D. Registrar

Per [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to June 18, 1927, that I last saw him alive on June 17, 1928, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Hypostasis of Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Gross & Microscopic

(Signed) R. Topper Smith, M. D.

June 20 1927 (Address) [redacted] BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial: June 21 1927

20 UNDERTAKER: Frank E. Trocchi Son — ADDRESS: 1906 E. Monument

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

West of Belair Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23278

CERTIFICATE OF DEATH.

29 E 23278

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (ST.) 27-41 (WARD)

2-FULL NAME George Small

(a) RESIDENCE NO. Overlea, (ST.) Belair Ave (WARD) East Md.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 1918

7 AGE: Years 9 | Months 6 | Days 18

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank R. Small Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rose J Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Frank R Small Jr

(Address) Hamilton Ave Evergreen

15 Filed JUN 27 1927 C. HAMPTON JONES, M. D. Registrar

per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14-27 19

I HEREBY CERTIFY, That I attended deceased from 6-18, 1927, to 6-14-27 19

that I last saw h— alive on 6-18-27, 19

and that death occurred, on the date stated above, at 6.30 AM

The CAUSE OF DEATH* was as follows:

Tetanus Neo.

(duration) yrs. mos 24 hrs ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What confirmed diagnosis? Lab. & clinical

(Signed) E.W. Teagarden M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

Chas. B. Heatwole M.D. Attending Phys. June 21/27

H.C. Jones Coroner

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL 6/22 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nall

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23279

CERTIFICATE OF DEATH.

E 23279

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St.) (Hospital) WARD

2-FULL NAME John Ryan

(a) RESIDENCE NO. 1739 William St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Ryan

6 DATE OF BIRTH (month, day, and year): June 4, 1887

7 AGE: years 39 Months Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Credit Assn of Balt

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John J Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Kristina Hossfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Barbara Ryan 1739 W Pratt St

15 Filed JUN 21 1927 19 HAMPSON JAMES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1927

I HEREBY CERTIFY, That I attended deceased from June 19, 1927, to June 20, 1927, that I last saw him alive on June 20, 1927, and that death occurred, on the date stated above, at 8 am m.

THE CAUSE OF DEATH* was as follows:

Probably Pneumonia

Also probably intra-cranial pressure

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Contusion

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Balt Md

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) W W Cullen M. D.

, 19 (Address) Franklin St Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6/23 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 526 Pratt

FROM A VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23280

CERTIFICATE OF DEATH.

161-001

E 23280
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lillian Swigert.

(a) RESIDENCE NO. 829 Colvert Rd. STR. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): 6/11/27

7 AGE: Years — Months — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry Swigert.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Florence Sutro. 6/20 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): West Balt. Gen. Records.

15 Filed N 21 1927 — J. HAMPSON JONES, M. D. Registrar — By R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/11 1927 to 6/17 1927, that I last saw her alive on 6/17 1927 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth 6 hrs.

due to Placenta previa

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gross Labor

(Signed) Charles H. Queen M. D.

(Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: June 21 1927

20 UNDERTAKER: W. Cook — ADDRESS: 500 E Madison

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23281 — 91-002 — E 23281

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 E. North Ave St. 13-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda M. Bradley

(a) RESIDENCE NO. 1010 E. North Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Lewis Bradley

6 DATE OF BIRTH (month, day, and year) March 12/1846

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	81	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Josiah Bowen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Susie R. Krank

(Address) Calvert Bldg. Balto. Co. Md.

15 Filed NOV 1 1927, 19 C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senility-Arteriosclerosis

(duration) .....yrs. .....mos. .....ds.

(Signed) _____, M. D.

(Coroner)

6/20/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial 6/21/1927

20 UNDERTAKER Wm Cook ADDRESS 502 E. N. Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23282

E 23282

PLACE OF DEATH Franklin Square Hospital — REGISTERED NO. 9-18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 year & 1 month) ST. — WARD

2-FULL NAME Clifton Chaney

(a) RESIDENCE NO. 1824 Aisquith ST. — WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

Male — 4 COLOR OR RACE: W — 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Chaney

6 DATE OF BIRTH (month, day, and year): Sept 6 1874

7 AGE — Years: 52 — Months: 9 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Thorpe Dohme

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Levy M Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edw. C Chaney

(Address) 1824 Aisquith St.

15 Filed [illegible] 19 [illegible] Registrar

N 2 1927

by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/16/27, 19 , to 6/20/27, 19 ,

that I last saw h~~e~~alive on 6/20/27, 19 ,

and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Gastric Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs

(Signed) William Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 23 1927

20 UNDERTAKER: W. H. Cook — ADDRESS: 502 E Baltimore

J. HAMPTON JONES, M. D. Registrar

by R.H.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23283

CERTIFICATE OF DEATH.

162 ✓

E 23283
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Puckett

(a) RESIDENCE NO. Mt Airy Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6d yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Boy

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/20/27

7 AGE. Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
a few hours			5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Matthew Puckett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) not given

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Matthew Puckett

(Address) Mt Airy Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1927, to 6-20, 1927, that I last saw him alive on 6-20, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Delaglisera, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Poplar Spring Md Date of Burial Jul 21 1927

20 UNDERTAKER: Easton Sons & Ellsworth ADDRESS:

Very important. See instructions on back of certificates.

Brosenne ✓

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23284

CERTIFICATE OF DEATH

X 137 E 23284

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

City of BALTIMORE: (No. St., 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brosenne

(a) RESIDENCE NO. Ellicott City, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward F. Brosenne

6 DATE OF BIRTH (month, day, and year): Sept. 17, 1884

7 AGE Years: 42 Months: 9 Days: 3 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Chamber

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Catherine Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: E. F. Brosenne (Address) Ellicott City Md.

15 Filed JUN 21 1927, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927. to June 20, 1927. that I last saw h er alive on June 20, 1927. and that death occurred, on the date stated above, at 7 50 A. m.

The CAUSE OF DEATH* was as follows:

Ovarian Cyst.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of June 15, 1927

Was there an autopsy? No -

What test confirmed diagnosis? -

(Signed) Thos. B. Turner, M. D.

6-20, 1927 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: June 22 1927

20 UNDERTAKER: Easton Son & Edwards ADDRESS

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23285

CERTIFICATE OF DEATH

90 ✓

E 23285

REGISTERED NO.

1-PLACE OF DEATH

9-50

City of BALTIMORE: (No. 2733 Greenmount Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel F. Tapman

(a) RESIDENCE NO. 2733 Greenmount Ave., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 9 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tapman

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	76	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Post Master

(c) Name of employer at Hamilton

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel F. Tapman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Gillett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) [illegible]

14 Informant Mrs. Mary P. Tapman

(Address) 2733 Greenmount Ave.

15 Filed JUN 21 1927

16 C. HAMPSON JONES, M. D. Registrar

Per [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to June 20, 1927, that I last saw h[illegible] alive on June 19, 1927, and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis and cholelithiasis with common duct obstruction. Cardiac decompensation (duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) 20 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shannon, M. D.

6/21/27 (Address) 3700 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial June 22 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23286

CERTIFICATE OF DEATH.

31 E 23286

1-PLACE OF DEATH U. S. Marine Hospital No 1 12-51 REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Hill.

(a) RESIDENCE NO. 145 Middle ave ST., WARD

(Usual place of abode) Gotmtown, Pa

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 4, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Ivy

(c) Name of employer John W M H Michael

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Paul Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Addie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Self.

(Address)

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

6 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1927

17 I HEREBY CERTIFY That I attended deceased from Jan. 12, 1927, to June 20, 1927, that I last saw him alive on June 20, 1927 and that death occurred, on the date stated above, at 5 20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of larynx

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hypersensitive laboratory tests

(Signed) W W Bentz, M. D.

Asst. Surgeon U.S.P.H.S.

6-20, 1927 (Address) U.S. Marine Hospital No 1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 21, 27

20 UNDERTAKER E. Leroy Stiffler ADDRESS 1256 E. North ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23287 E 23287

CERTIFICATE OF DEATH.

18-003

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. St., Ward)

2-FULL NAME Wm. T. Fowler

(a) RESIDENCE NO. 2924 Brighton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M Fowler

6 DATE OF BIRTH (month, day, and year): Oct 8th 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	61	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore (State or country): Md

PARENTS

10 NAME OF FATHER: Alfred Fowler

11 BIRTHPLACE OF FATHER (city or town): Balto (State or country): Md

12 MAIDEN NAME OF MOTHER: Georgeanna Hawkins

13 BIRTHPLACE OF MOTHER (city or town): Balto (State or country): Md

14 Informant: William E Fowler

(Address): 123 Leeds ave

15 Filed June 25 1927 19 C. HAMPSON JONES M. D. Registrar

By K K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy (Coroner) M. D.

June 25, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial: June 22nd 1927

20 UNDERTAKER: George Schilling & Sons ADDRESS: 1126 E Monument St

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23288 — 31 — E 23288

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals (11:24) St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stroud

(a) RESIDENCE NO. 1017 Madison ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Stroud

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Track laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..., 19 ... Registrar

JUN 21 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from May 24, 19 27, to June 19, 19 27,

that I last saw him alive on June 19, 19 27,

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unk. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gaither, M. D.

6-19-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

National Cem — June 21/1927

20 UNDERTAKER — ADDRESS

Lamb & Epton — Balto

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23289

CERTIFICATE OF DEATH.

E 23289

1-PLACE OF DEATH

REGISTERED NO. 17-23 187-006

City of BALTIMORE: (No. Colored Home St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walker Freeman

(a) RESIDENCE NO. 819 N. Freemon St. and Ward

(Usual place of Abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Freeman

6 DATE OF BIRTH (month, day, and year) about 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Monumental Foundry Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Freeman

(Address) 819 N. Freemon

15 Filed JUN 21 1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held no (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial June 21 1927

20 UNDERTAKER David Easton ADDRESS 916 Car

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

20 E/23290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+52 E 23290

REGISTERED NO._____

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No._____ St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Judge Daniel Price Withers

(a) RESIDENCE NO. 1032 Main St. St. _____ Ward Roanoke Va.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Corporate Judge

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER E. Withers

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Lena Price

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Reeds

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 1 1927 C. HAMPSON JONES, M. D. Registrar

By RF

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1927, to June 20, 1927, that I last saw h-- alive on June 20, 1927, and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

Chronic Hypertension Post

Tuberculosis

(duration) 21 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/5/27

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem

(Signed) C H Sharp M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va. Date of Burial 6-22 1927

20 UNDERTAKER N. A. Watkins Son Co ADDRESS McCulloch & Clark

Key Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23291

CERTIFICATE OF DEATH.

113 ✓ E 23291

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Keenan

(a) RESIDENCE NO. 929 Valley St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Jan 12 /26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER James Keenan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Agnes Byrne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant James Keenan

(Address) 929 Valley St

15 Filed 6 21 1927 19 C. HAMPSON JONES, M. D. Registrar

Per A.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) C. H. Jones, M. D. (Coroner)

6/21/27 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 6/21 19 27

20 UNDERTAKER George & Ruth ADDRESS 1735 Harford Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23292

CERTIFICATE OF DEATH.

31 ✓ E 23292

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE. (No. 2330 Mulliman St., 7 12 Ward)

2-FULL NAME Margaret Stember

(a) RESIDENCE NO. 2330 Mulliman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~. (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Late Henry Stember

6 DATE OF BIRTH (month, day, and year) April 20-1869

7 AGE: Years 58 | Months 1 | Days 28 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Emby

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Anna Dippolt

(Address) 4505 Maidlene

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

JUN 21 1927 per R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 27 19

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 18, 1927

that I last saw h.. alive on June 17, 1927

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Intramural Fibroma

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred C. Fuguay, M. D.

June 20 1927 (Address) 714 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem Date of Burial June 22 1927.

20 UNDERTAKER: Dud C. Miller & Son ADDRESS 2334 Jeffer...

Very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23293

E 23293

CERTIFICATE OF DEATH.

Registered No. C. 109

1-PLACE OF DEATH

City of BALTIMORE: (No. New Baltimore General Hospital St., 126-64 Yard)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Gerald Greenhaw

(Residence in Baltimore: No. 3309 Norwood Ave St.; yrs., 2 mos. — ds.)—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-Single, ~~Married, Widowed,~~ or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Aug 15th 1920
(Month) (Day) (Year)

7-AGE. 6 yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Schoolboy
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Kansas City Mo.

PARENTS.

10-NAME OF FATHER. Horace Greenhaw

11-BIRTHPLACE OF FATHER, (State or Country) Fair Play Mo.

12-MAIDEN NAME OF MOTHER. Helen A Colvin

13-BIRTHPLACE OF MOTHER. (State or Country) Clinton Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace Greenhaw

(Address) 3309 Norwood Ave

15-

JUN 21 1927

G. HAMPSON JONES, M. D. Registrar.

Per LCK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH June 20th 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Laceration of liver

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Operation for

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

June 21 1927 (Address) 2 E Chesapeake

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cemt DATE OF BURIAL. June 22nd 1927

20-UNDERTAKER. Leitam & Pore ADDRESS 1723 W. Lafayette Ave

is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—500 Bks.

E 23295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

† 129 ✓ E 23294

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 Monastery ave St. 20-71 Ward)

2-FULL NAME Henry Baldry.

(a) RESIDENCE NO. Pasadena Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 21 ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Baldry

6 DATE OF BIRTH (month, day, and year) October 14-1849.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	8	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 66

(b) General nature of industry, business, or establishment in which employed (or employer) Tax-Service

(c) Name of employer Prentice-Hall.

9 BIRTHPLACE (city or town) Cambridge

(State or country) England.

PARENTS

10 NAME OF FATHER Joseph Baldry.

11 BIRTHPLACE OF FATHER (city or town) Cambridge

(State or country) England.

12 MAIDEN NAME OF MOTHER Rhoda Sloane.

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Ireland.

14 Informant Valleau Pratt.

(Address) Pasadena Md.

15 Filed ... 19 ... H. A. ... Registrar

NOT 19 27 R.H.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19-1927.

17 I HEREBY CERTIFY, That I attended deceased from March 9- 1927, to June 19- 1927, that I last saw h.~~im~~ alive on June 19- 1927, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) unknown yrs. mos. ds.

CONTRIBITORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & hematuria

(Signed) Chester Riland, M. D.

6-19-, 1927 (Address) 2532 Edmondson ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park June 23 1927

20 UNDERTAKER John O. Mitchell ADDRESS 900 Eutaw St.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23295 — 161-001 — E 23295

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Fields

(a) RESIDENCE NO. 910 Shuter St St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-2-27

7 AGE — Years | Months | Days 14 | IF LESS than 1 day ....hrs. or ....min.: 24 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER Mc Kinley Fields

11 BIRTHPLACE OF FATHER (city or town): Md —

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Hall

13 BIRTHPLACE OF MOTHER (city or town): Md —

(State or country)

14 Informant: Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

21 1927 1476 ARR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-16-27

17

I HEREBY CERTIFY, That I attended deceased from 6-16-27, 19...., to 6-16-27, 19....,

that I last saw him alive on 6-16-27, 19....,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ridgeway Trumbo M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL JUN 20 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23296 — 161-001 — E 23296

CERTIFICATE OF DEATH.

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Lee

(a) RESIDENCE NO. 1509 N. Eutaw St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/19/27

7 AGE	Years	Months	Days	IF LESS than 1 day ..9.. hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..0..

(b) General nature of industry, business, or establishment in which employed (or employer) ..0..

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto, Md

PARENTS

10 NAME OF FATHER Marvin Lee

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Texas

12 MAIDEN NAME OF MOTHER Doris Stein

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto, Md

14 Informant _____

(Address)

15 Filed _____, 19 _____ Registrar

1927 1172

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-19-27

17

I HEREBY CERTIFY, That I attended deceased from 6-19, 1927, to 6-19, 1927, that I last saw h.C.L. alive on 6-19, 1927 and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY _____
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Clinical test

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

G. HAMPSON JONES M.D.

JOHNS HOPKINS HOSPITAL

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23297

CERTIFICATE OF DEATH

161-60 E 23297

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 953 Madison Av St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dorsey

(a) RESIDENCE NO. 953 Madison Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant (dau)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Josiah Dorsey

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Dorsey

13 BIRTHPLACE OF MOTHER (City or town) Baltimore

(State or country) Md

14 Informant

(Address)

15 June 19 1927 C. HAMPSON JONES, M. D. Registrar

1474 APA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 17

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1927, to June 17, 1927, that I last saw h alive on June 17, 1927, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

, 19 (Address) 720 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.

DEPARTMENT OF OCCUPATION 18

Spec.–7-17-26—A Co.—200 Bks.

E. 23298

Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 23298

161-002

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 929 N Wolfe St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Davis

(a) RESIDENCE NO. 929 N Wolfe St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 6-19-1927

7 AGE Years Months Days IF LESS than 1 day hrs. or 5 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Jeff Davis

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Moseley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Mary Moseley

(Address) 929 Wolfe St

15 Filed 6-21, 1927 _____ Registrar

1467 ASN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-19, 1927, to 6-19, 1927, that I last saw h.. alive on 6-19, 1927, and that death occurred, on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH* was as follows:

Prenatal Causes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted _____

if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Physical Examination

(Signed) _____ M. D.

6-19, 1927 (Address) 708 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23299

CERTIFICATE OF DEATH

E 23299

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Maryland General Hospital St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Angeline Utz

(a) RESIDENCE NO. Hampstead Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Utz

6 DATE OF BIRTH (month, day, and year): 11-5-1850

7 AGE: Years 76 Months 8 Days 16 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Brahlitz

11 BIRTHPLACE OF FATHER (City or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Mary Lawson

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hosp. Records (Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21-1927

17 I HEREBY CERTIFY, That I attended deceased from 6-19-27, 19..., to 6-21-27, 19..., that I last saw her alive on 6-21-27, 19..., and that death occurred, on the date stated above, at 4:10 A m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder

(Acute symptoms 40 hrs. duration)

(duration) ... yrs. ... mos. ? ds.

CONTRIBUTORY (Secondary) Toxemia 40 hrs.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 6-19-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Jamison M. D.

, 19 (Address) Md. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Md Date of Burial June 23 1927

20 UNDERTAKER: Edw. F. Tipton ADDRESS: Hampstead Md

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23300

CERTIFICATE OF DEATH.

57 E 23300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St 15-63 Ward)

2-FULL NAME Mrs Cecilia Skrentny

(a) RESIDENCE NO. 4103 Belle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 1 ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Skrentny.

6 DATE OF BIRTH (month, day, and year) 8/16/1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country) not given

PARENTS

10 NAME OF FATHER Wojciech Gerwinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " Poland

12 MAIDEN NAME OF MOTHER " " Cecilia Gerwinski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " " Poland

14 Informant Henry Skrentny

(Address) 4103 Belle Ave

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1927

17

I HEREBY CERTIFY, That I attended deceased from 6-13, 1927, to 6-19, 1927, that I last saw her alive on 6-19, 1927, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis - Cholelithiasis - Chronic

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes - Postoperative

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 6-18-27

Was there an autopsy? no

What test confirmed diagnosis? operation & clinical tests.

(Signed) A. J. Knapp, M. D.

6/19, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Hannis Lane. Date of Burial 6/22 1927

20 UNDERTAKER Wm. Fialkowski ADDRESS 618 Eastern

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

2 E 23301

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23301

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hardin H Reynolds

(a) RESIDENCE NO. Critz Va. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 da.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Reynolds.

6 DATE OF BIRTH (month, day, and year) 2 2 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va —

(State or country)

PARENTS

10 NAME OF FATHER Hardin Reynolds

11 BIRTHPLACE OF FATHER (city or town) Va -

(State or country)

12 MAIDEN NAME OF MOTHER Nancy Cox

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant Reads -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1927, to June 21 1927, that I last saw h.im alive on June 21 1927, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

septic embolis from thrombosis of left leg

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) urinary retention

(duration) yrs. 8 mos. da.

18 Where was disease contracted if not at place of death? Critz Va

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Hahn-Kelly, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Critz, Patrick Co. Va Date of Burial June 2, 1927

20 UNDERTAKER Hughes & Jones Inc. ADDRESS 422 N. Broadway

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23302

CERTIFICATE OF DEATH.

47 E 23302

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 922 St Paul St 4-24 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Gertrude Donellan

(a) RESIDENCE NO. 922 St Paul St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
? ? 1883

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER James Donellan
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland
12 MAIDEN NAME OF MOTHER Catherine Hanrahan
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant K Z Donellan
(Address) 922 St Paul St

15 Filed 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from February 24th 1926 to June 19th 1927, that I last saw h[illegible] alive on June 19th. 1927, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with general metastasis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Edgar D. Perkins, M. D.
, 19 (Address) 1 West Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem Date of Burial 6/22/27

20 UNDERTAKER Wm J. Lakey Sons ADDRESS 1818 Eight St

Very Important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23303

CERTIFICATE OF DEATH

129 E 23303

1-PLACE OF DEATH

REGISTERED NO. 15-21

City of BALTIMORE: (No. Md General Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hawkins

(a) RESIDENCE NO. 1730 Calhoun St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Walter Hawkins

6 DATE OF BIRTH (month, day, and year): Jan. 3. 1870

7 AGE: Years 58 Months 5 Days 15 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carthagena (State or country) Md

PARENTS

10 NAME OF FATHER Jno Hawkins

11 BIRTHPLACE OF FATHER (City or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant (Address) Mrs Rena

15 Filed JUN 22 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R A

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6. 18. 1927

17 I HEREBY CERTIFY, That I attended deceased from 6.16.1927 to 6.18.27 19 ..., that I last saw h.. alive on 6.18.27 19 ..., and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH was as follows:

Ch. Dil Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thad Longaker M. D.

6/18/27 19 (Address) 1730 Calhoun St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C. Date of Burial: June 23 27

20 UNDERTAKER: Edmund D Heinsley ADDRESS 5 E Biddle

very important. See instructions on back of certificates.

...ion in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

E 23304

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23304

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. (Ward) 14-20

2-FULL NAME Henrietta Gray

(a) RESIDENCE NO. 1423 Argyle Ave St. Ward 4V

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lawrence Gray

6 DATE OF BIRTH (month, day, and year): June 25-1907

7 AGE — Years: 19 Months: 11 Days: 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md-

(State or country)

10 NAME OF FATHER: James Clark

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Alice Outland

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

PARENTS

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 22 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 19, 1927, that I last saw h.e alive on June 19, 1927, and that death occurred, on the date stated above, at 12 40 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous enteritis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 6/18-27.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Hubert L. Faust, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial June 22 1927

20 UNDERTAKER: Samuel Ormsby ADDRESS 538 N. Eutaw St.

Key Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23305 — 75-001 — E 23305

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Grill

(a) RESIDENCE NO. 1106 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): June 1875

7 AGE: Years 52 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 63

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed June 22 1927 C. HAMPSON JONES, M. D. Registrar

Per R.F.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 21, 1927, that I last saw him alive on June 20, 1927, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

Residual at hemiplegia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) C. Hampson Jones M. D.

June 22 1927 Address BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — Date of Burial: June 22 1927

20 UNDERTAKER: Wm. A. Fields — ADDRESS: 1200 N. Lonsdale

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23306

CERTIFICATE OF DEATH.

E 23306

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4500 Kathland Ave St. 28-61 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Julius Price

(a) Residence No. 4500 Kathland Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single,~~ Married, ~~Widowed~~ or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Elizabeth C. Price

6-DATE OF BIRTH (month, day and year) March 1, 1847

7-AGE, 80 yrs. 3 mos. 20 ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: draughtsman

(b) General nature of industry, business, or establishment in which employed (or employer): (retired) unemployed for last years

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md.

PARENTS.

10-NAME OF FATHER, John H. Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER, Justina Willard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md.

14- (Informant) Mrs. Grace Colvin

(Address) 4500 Kathland Ave.

15- [illegible] 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20, 1927

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1927 to June 20, 1927 that I last saw him alive on June 19, 1927 and that death occurred, on the date stated above, at 1.55 a. m.

The CAUSE OF DEATH* was as follows:

(senility) generalized arteriosclerosis

about 2 (Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) myocardial insufficiency

(Duration) yrs. 2 mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? usual test.

(Signed) George A. Kuipe M. D.

19 (Address) 5030 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem — DATE OF BURIAL, June 22, 1927

20-UNDERTAKER, Jno. L. Jackson, Jones — ADDRESS [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23307 E 23307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 9292 Preston St. 10-14 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Noonan

(a) RESIDENCE. NO. 9292 Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 40	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Weaver & Mattresses

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jeremiah Noonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Hennessy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Elizabeth Noonan
(Address) 9209 E. Preston st

15 Filed JUN 22 1927 19 C. HAMPSON JONES, M. D. Registrar
Dar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1927, to June 21 1927
that I last saw h[illegible] alive on June 21 1927
and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Mitral Regurgitation
(Duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Rheumatism
(durstion) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Harry L. Rutzebeck M.D.
6-24-1927 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 25 1927

20 UNDERTAKER Johannah Carbo ADDRESS 1004 Aisquith st

Fill in very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23308

CERTIFICATE OF DEATH.

46

E 23308

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 - Rose ST.: 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Irene Payne

(a) RESIDENCE. NO. 2005 - Rose. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barton Payne

6 DATE OF BIRTH (month, day, and year): June 12 1856

7 AGE: Years 56 | Months 11 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Alfred Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Amanda Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Barton Payne
(Address): 2005 - Rose St -

15 Filed JUN 22 1927 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17 I HEREBY CERTIFY that I attended deceased from June 15 1927, to June 21, 1927, that I last saw her alive on June 21, 1927, and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Thrombosis
(duration) Some days

CONTRIBUTORY (Secondary) Pneumonia
Illness (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee Anderson, M. D.
June 21 1927 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: June 23 1927

20 UNDERTAKER: Wm Cole — ADDRESS: 502 E North Ave

Spec.—12-9-25—A Co.—200 Blks.

E 23309

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23309

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Halbig

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	10	19 (21)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed JUN 22 1927 C. HAMPSON JONES, M. D. Registrar

Post

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 21st

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to June 21 1927, that I last saw h.e alive on June 19, 1927, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

unknown (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

June 21, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer June 22 1927

20 UNDERTAKER — ADDRESS

D. Rita Mudfield 914 Gramm Pl

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23310

CERTIFICATE OF DEATH.

101-001 E 23310

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Clark.(C)

(a) RESIDENCE NO. 304 N.High St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Widow.

5a If married, widowed, or divorced
(or) WIFE of George Clark (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harrisonburg, Va.

PARENTS

10 NAME OF FATHER Jacob Spangler.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sally Parker.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Robert Spangler.(C)brother.

(Address) 439 Ridge St. Washington, D.C.

15 Filed JUN 22 1927 C. HAMPSON JONES, M. D. Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

6/21 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 304 N. High St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Date of Burial 6/22 1927

20 UNDERTAKER Byron Wright McElderry ADDRESS 1218

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23311

CERTIFICATE OF DEATH.

REGISTERED NO. E 23311

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Spring ST. 59 WARD)

2-FULL NAME Goldie Squirell

(a) RESIDENCE NO. 411 N Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wadell Squirell

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
27				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Geo co

12 MAIDEN NAME OF MOTHER: Martina Pinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: Martina Banks (Address) 411 N. Spring

15 Filed ....., 19.... Registrar: H. HAMPTON JONES, M. D. Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 . 1927.

17 I HEREBY CERTIFY That I attended deceased from June 17 . 1927 . to June 20 . 1927 . that I last saw h[illegible] alive on June 20 . 1927 . and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral

Lobar.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) George D. Allen M. D.

June 20 1927 (Address) 508 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemty

DATE OF BURIAL: 6/23 1927

20 UNDERTAKER: Byron Wright

ADDRESS 1218 McElderry

Spec.-7-17-26—A Co.—200 Bks.

E 23312

HEALTH DEPARTMENT—CITY OF BALTIMORE

+202 E 23312

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 Guilford Ave St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes Osborne

(a) RESIDENCE NO. 1115 Guilford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/17/1905

7 AGE — Years: 71 Months: 8 Days: 10 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Emp. in Morris Store

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Geo Osborne

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Mary Schnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Husband.

15 Filed JUN 22 1927 19 C. HAMPSON JONES, M. D. Registrar

H.A.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/27

17 I HEREBY CERTIFY, That I attended deceased from 6/21-27 19 ..... to 6/22/27 19 .....

that I last saw h alive on 6/22/27 19 .....

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Septicemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gen paralysis

(duration) yrs. mos 2

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/22/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Donaldson, M. D.

6/22, 19 (Address) 1115 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Oxford Pa — Date of Burial: 6/25-1927

20 UNDERTAKER: H Barnard & Son — ADDRESS: Washington

Very important. See instructions on back of certificates. ... OCCUPATION 18

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23313
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

20-27

3/V E 23313
REGISTERED NO.

City of BALTIMORE: (No. 524 Brice St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Tomlinson

(a) RESIDENCE NO. 524 Brice St. ... Ward ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 23-1907

7 AGE — Years: 19 — Months: 9 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): 004
(c) Name of employer: Md. Casualty Co.

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md.

PARENTS

10 NAME OF FATHER: Harry J. Tomlinson
11 BIRTHPLACE OF FATHER (city or town): Balto.
(State or country): Md.
12 MAIDEN NAME OF MOTHER: Catherine A. Lyngan
13 BIRTHPLACE OF MOTHER (city or town): Balto.
(State or country): Md.

14 Informant: Harry J. Tomlinson
(Address): 524 N. Brice St.

Filed ..... 19 .....
Per ..... Registrar

22 1927

C. HAMPSON GONTRUM, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1927, to June 21, 1927, that I last saw h... alive on June 20, 1927 and that death occurred, on the date stated above, at 7.9 ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) 1 yr 4 ... mos. ... ds.

CONTRIBUTORY (Secondary): Laryngeal T. B.

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Oliver Murray, M. D.
, 19 (Address) 1517 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: June 24 1927

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

KEY important. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 23314

REGISTERED NO.

E 23314

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1505 N. Payson St. City

(a) RESIDENCE NO. Mrs Rose Levene St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Levene

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Jacob Levene

(Address) 1505 N. Payson St

15 Filed 19 HAMPSON JONES, M. D. Registrar

NOV 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 1927

17

I HEREBY CERTIFY, That I attended deceased from 6-7 1927, to 6-22, 1927, that I last saw her alive on 6-22, 1927, and that death occurred, on the date stated above, at 5:35 p. m.

The CAUSE OF DEATH* was as follows:

Peritonitis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pan-hysterectomy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. Dadaglianca M. D.

6/22 1927 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nat. Ben Date of Burial 6/22 1927

20 UNDERTAKER Jack Levin ADDRESS 1439 E Baltimore St

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 23315

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 21-29 REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Muse

(a) RESIDENCE NO. 745 Ryan St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Butler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Duncan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 BALTIMORE CITY HOSPITALS

(Address) Records

C. HAMPSON JONES, M. D.

15 Filed ....., 19 .....

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to June 19, 1927, that I last saw h.. alive on June 18, 1927, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ....yrs. ?mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! no

What test confirmed diagnosis! general & Laboratory

(Signed) E Boogu Smith, M. D.

June 20 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn Cemetery June 22 27

20 UNDERTAKER ADDRESS,

John H Faadun 847 Druid Hill Ave

June 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 23316

CERTIFICATE OF DEATH.

E 23316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 921 Parrish ST. 16-22 WARD)

2-FULL NAME Melba Brown

(a) RESIDENCE NO. 921 Parrish ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 28 26

7 AGE: Years — Months: 5 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Frank Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Esther Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Frank Brown

(Address): 921 Parrish St.

15 Filed: JAN 2 1927 Registered:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21st 27

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 19 27 to June 21st 19 27

that I last saw her alive on June 21st, 1927

and that death occurred, on the date stated above, at 10.15 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uncomplicated

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Was Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: June 21 27

20 UNDERTAKER: Edward H. Stanley ADDRESS: 1708 Madison

HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

Chandler ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

2038 E 23317 — CERTIFICATE OF DEATH. — 129 E 23317

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Chandler

(a) RESIDENCE NO. 42 Franklin St. N.E. Washington D.C. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edna Chandler

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 48; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER: Andrew Chandler

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Wells

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

6 22 1927 By R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to June 22, 1927, that I last saw him alive on June 22, 1927, and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W Lindsay Miller, M. D.

6/27/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D C — Date of Burial: June 22 1927

20 UNDERTAKER: D. Martin W Hysong — ADDRESS: Washington D.C. 1300 N St NW

Directions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23318

E 23318

CERTIFICATE OF DEATH.

188-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital 2866 Ward)

2-FULL NAME Charles Conrad Kraft

(a) RESIDENCE NO. 602 Cooks Row SW Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Kraft

6 DATE OF BIRTH (month, day, and year) December 24, 1868

7 AGE	Years	Months	Days 26	IF LESS than 1 day.....hrs. or.....min.
	58	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Overseer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jenkens Estate

9 BIRTHPLACE (city or town) Baltimore ~~County~~

(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Kraft

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna McCormick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Eugene Kraft

(Address) 600 North Cooks Row

15 Filed JUL 2 1927 19 C. HAMPSON JONES, M. D. Registrar

By R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Spine — Possible Fract Skull Injuries Struck by Street Car

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

6/21. 1927 (Address) Curtis and Cedar Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 6/23 1927

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 West Baltimore St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23319 129 E 23319

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Leahy.

(a) RESIDENCE NO. 1404 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. H. Leahy

6 DATE OF BIRTH (month, day, and year): April 8-1861

7 AGE: Years 66 Months 2 Days 12 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Galtond

PARENTS

10 NAME OF FATHER: Michael Cullen

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary [illegible] Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Geo. H. Leahy

(Address): 1404 Hanover St

15 June 27 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 24 27

17 I HEREBY CERTIFY, That I attended deceased from May 29, 19 27, to June 24, 19 27,

that I last saw h[illegible] alive on June 1, 19 27,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cer Sclerosis & Myocarditis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Albuminuria)

(duration) about month yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

June 29 19 27. (Address) 3 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: June 30 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 14 W Eager St

very important. See instructions on back of certificates.

...property classified. Last statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23320

E 23320

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Rosemont Ave. St. 27-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Martin,

(a) RESIDENCE NO. 1 Rosemont Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Martin,

6 DATE OF BIRTH (month, day, and year) April 24.1851

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Martin,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Edward J. Ruhl.

(Address) 1 Rosemont Ave.

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 20 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 18 1927, to June 20 1927,

that I last saw h[illegible] alive on June 20 1927,

and that death occurred, on the date stated above, at 8 10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. 20 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edward Benson, M. D.

June 21 1927 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial June 23 1927

20 UNDERTAKER Geo. F. Lilley — ADDRESS

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23321

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23321

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 205 E. North ave ST., 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Esther Nicolls

(a) RESIDENCE NO. 205 E North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 31-1862

7 AGE: Years 64 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gloster Co Court House Va

PARENTS

10 NAME OF FATHER: Robt A Nicolls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mardella Springs Md

12 MAIDEN NAME OF MOTHER: Mary Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Salisbury Md

14 Informant: Robt W Nicolls

(Address): 205 E North ave

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

2 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to June 21, 1927, that I last saw her alive on June 21, 1927 and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 205 East North Ave.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Ocular exam

(Signed) C. Hampson Jones, M. D.

6/21, 1927 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 6-23 1927

20 UNDERTAKER: Robert Burke & Son

ADDRESS: Catonsville Md

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23322 ✓ E 23322

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 S Payson St., St. 70-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Howard

(a) RESIDENCE NO. 411 S Payson St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie G. (nee Young)

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Farber Specialty Co.,

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Annie Howard (Address) 411 S Payson St.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to June 20, 1927, that I last saw h[illegible] alive on June 20, 1927, and that death occurred, on the date stated above, at 10. a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsis

(Signed) Wallace A Cox, M. D.

6/20 1927 (Address) 534 S Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 6/23 1927

20 UNDERTAKER Harry H. Weitzel

ADDRESS 1531 W. Lombard

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23323 E 23323

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3840 Falls Road ST., 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel C. Frazier

(a) RESIDENCE NO. 3840 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles K. Frazier

6 DATE OF BIRTH (month, day, and year): Feb. 13-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Geo. H. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Hannah Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Charles K. Frazier

(Address): 3840 Falls Road

15 Filed 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1925 to June 21 1927

that I last saw her alive on June 20 1927

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Inflammatory Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Ch valv heart disease (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Compare

(Signed) C. Hampson Jones M. D.

6/21. 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Balto. Co.

DATE OF BURIAL: June 23 1927

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 3631 Falls Road

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23324

E 23324

CERTIFICATE OF DEATH

Mt. Winans

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospitals 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hermann Neadberger Mt. Winans

(a) RESIDENCE NO. 2207 Linden Av. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 58 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Germany

PARENTS

10 NAME OF FATHER: Dont know.

11 BIRTHPLACE OF FATHER (city or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany.

14 Informant: Mrs. Rose Price (Step Daughter)

(Address) 1338 E. Fort Ave

15 Filed June 19 27 C. HAMPSON JONES M. D. Registrar

1927 Per RPH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21- 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) Exhaustion yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

June 21/2 19 (Signed) G. C. Bates (Coroner) M. D.

(Address) 143 N Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial June 24 1927.

20 UNDERTAKER: A. Howard Evans ADDRESS 3.E. Fort Ave.

Any information on this certificate. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23325 129 E 23325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 W 36th St. ST.) 13-57 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy I. Slough

(a) RESIDENCE NO. 1435 W 36th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: John A. Slough

6 DATE OF BIRTH (month, day, and year): May 20, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	79	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Ella Slough

(Address) 1435 W 36th St

15 Filed 6/25 1927, 19 Registrar R.C. C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 21, 1927,

that I last saw h[er] alive on June 21st, 1927

and that death occurred on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hig BP. Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary findings

(Signed) W. A. Fennel, M. D.

6/6/1927 (Address) 3616 Foles Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cem

DATE OF BURIAL: June 24 1927

20 UNDERTAKER: Chenowith Son

ADDRESS: 3615 Gwynn Oak Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23326

CERTIFICATE OF DEATH.

10 E 23326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) 4-33 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tudor

(a) RESIDENCE No. 403 Saunders St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 7, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Tudor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Loretta A?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant William Tudor

(Address) 403 Saunders St

15 Filed JUN 23 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1927, to June 21, 1927, that I last saw him alive on June 21, 1927 and that death occurred, on the date stated above, at 11.50 p m

The CAUSE OF DEATH* was as follows:

Nasal & Pharyngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Cult.

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL June 23 1927

20 UNDERTAKER J. F. McCully ADDRESS 178 E Fort

Spec.—1-12-23—M&T—500 Blks.

E 23327 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23327

CERTIFICATE OF DEATH. 10-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) 707-53 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Ciocle Eby

(a) RESIDENCE No. 411 Woodlawn Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 2, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER C. A. Eby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Ethel Ciocle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant C. A. Eby

(Address) 411 Woodlawn Rd

15 Filed JN 23 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to June 22, 1927, that I last saw her alive on June 22, 1927 and that death occurred, on the date stated above, at 7 a.m. The CAUSE OF DEATH* was as follows:

Nasal, Tons. & Pharyngeal Diphtheria

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Post Mort.

(Signed) Myron S. Tull, M. D.

6/22 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL June 23 19

20 UNDERTAKER

ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23328

CERTIFICATE OF DEATH

31

E 23328

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals (20-27) St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Kelly

(a) RESIDENCE NO. 1914 Vine st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Kelly

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed JUN 23 1927, 19 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 19 27, to June 20, 19 27

that I last saw him alive on June 20, 19 27,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Gaither, M. D.

6-21-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 6/25 19 27

20 UNDERTAKER John J. Fields ADDRESS 1200 N. Fremont

Very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23329 — 111-001 — E 23329

1-PLACE OF DEATH St Joseph's Hospital — REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Royston Hall.

(a) RESIDENCE NO. 1725 N. Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Hall.

6 DATE OF BIRTH (month, day, and year): Nov. 28/1888

7 AGE — Years: 38 — Months: 6 — Days: 24 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Moving Picture Manager

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Geo W Hall

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town): Not known

(State or country)

14 Informant: Royston Hall.

(Address) 1725 N. Washington

15 Filed ____ 16 C. HAMPSON JONES, M. D. Registrar

Per R.R.

23 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22— 27 — 19

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 27, to June 22 19 27.

That I last saw him alive on June 22 19 27

and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer (Ruptured

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary): Peritonitis 2

(duration) ____ yrs. ____ mos. 2 days.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of June 21-27

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) Frank R. DeSaulo, M. D.

, 19 (Address) 323 West North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: June 25 1927

20 UNDERTAKER: Henry Lutz — ADDRESS 203 N. Broadway

Very important. See instructions on back of certificates. Statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23330

CERTIFICATE OF DEATH.

186-003

25-75

E 23330

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert William Schultz.

(a) RESIDENCE NO. 832 Maryland Ave. Brooklyn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) June 22, 1919.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	7	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles E. Schultz.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Florence M. Fischer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Charles E. Schultz. (father)

(Address) 832 Maryland Ave. Brooklyn.

15 Filed 23 1927 16 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the limbs. Shock. Struck, knocked down and run over by an auto truck. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. M. Bernardt M. D. (Coroner)

6/28 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Patapsco Ave. nr. 4th St. Brooklyn.

Former or usual residence June 20, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Lutheran Date of Burial 4/23 1927

20 UNDERTAKER Geo. Weber Son 2503 Edmondson ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23331

CERTIFICATE OF DEATH.

188-003 ✓ E 23331

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 1-3 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Kowalski.

(a) RESIDENCE NO. 2228 Cambridge St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) February 16, 1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	13	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Kowalski.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Blaszzak.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Frank Kowalski. (father)

(Address) 2228 Cambridge St.

Rec'd JUN 23 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, struck and knocked down by an automobile.
Accidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Hoke Kershaw M. D. (Coroner)

b/28 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Pratt nr. Jay Sts. June 20, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial June 24 '27

20 UNDERTAKER F. W. Ozazewski ADDRESS 1930 Eastern

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23332

CERTIFICATE OF DEATH

38 E 23332

1-PLACE OF DEATH Balto City Hospl. 6-21

City of BALTIMORE: (No. Balto Md St. 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Coleman

(a) RESIDENCE NO. 1097 N. Carlton St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~one~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed or divorced. HUSBAND of (or) WIFE of Carrie Coleman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
57				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Laborer~~

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospl

(Address) ~~C. HAMPSON JONES, M. D.~~

15 Filed JUN 23 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6-20-27

17 I HEREBY CERTIFY, That I attended deceased from 5-14, 1927, to 6-20, 1927, that I last saw h alive on 6-19-, 1927, and that death occurred, on the date stated above, at 4,11 A m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis w/ Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry H. Adams M.D.

6/20, 19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery Date of Burial 6/23 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23333 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S. Sixth ST 26-37 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Lanz

(a) RESIDENCE No. 817 S. Sixth ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lanz.

6 DATE OF BIRTH (month, day, and year) July 4-1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min
	73	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Heinlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunda Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Lanz (Address) 817 S. Sixth St.

15 Filed JUN 23 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 12, 1927, to June 21, 1927, that I last saw her alive on June 20, 1927, and that death occurred, on the date stated above, at 2.40 P m

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of June 1, 27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C.O. Rufschneider, M. D.

6/22, 1927 (Address) 2439 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL June 24, 1927

20 UNDERTAKER George W. Zinkler ADDRESS 1731 E. Eager st

Spec.—1-12-23—M&T—500 Bks.

Angline McLeran

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23334

CERTIFICATE OF DEATH.

86-002

E 23334

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Univ Hospital ST. 27-54 WARD)

2-FULL NAME Angline McLeran

(a) RESIDENCE NO. Kent Road Mt. Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6. 1920

7 AGE — Years: 6 — Months: 7 — Days: 17 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm A. McLaren

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nash D.C.

12 MAIDEN NAME OF MOTHER: Lillie Holz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Wm A. McLaren Kent Road Mt Wash

15 Filed: NOV 23 1927 Registrar: C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-16 1927 to 6-23 1927

that I last saw h[illegible] alive on 6-23-27, 19

and that death occurred, on the date stated above, at 2:30 Am.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6-22-27

Was there an autopsy? no - Diagnosis

What test confirmed diagnosis? Clinical + lab. test

(Signed) J. C. Elliott M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 24 1927

20 UNDERTAKER: Wm O. Mitchell — ADDRESS: 1900 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23335

CERTIFICATE OF DEATH.

E 23335

27-44 188-003

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. St. Joseph Hospital St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur C. Knouss

(a) RESIDENCE NO. 211 Beverly Road- Beverly Hil Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) July 15/1907

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto- Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER J. Cecil -nouss

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Missouri

12 MAIDEN NAME OF MOTHER M. Louise Keiner

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Balto., Md.

14 Informant Mrs. M. Louise Knouss

(Address) 211 Beverly Road

15 Filed ____ 19 ____ Registrar

3 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 23/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull - Struck by Auto- mobile while riding motorcyle at Harford & Forsuch Aves.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Prass M. D.

(Coroner)

6/25/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial June 27/1927

20 UNDERTAKER H. Lander Sons ADDRESS 1710 Pleasant St

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23336 (upper left) E 23336 (upper right)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3720 Greenmount Ave St. 2-4 Ward)

2-FULL NAME Mary E. Bennett

(a) RESIDENCE NO. 120 S. Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29 1858

7 AGE	Years	Months	Days 23	IF LESS than 1 day.....hrs. or.....min.
	69	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant William Jacobs

(Address) 120 S Washington St

15 Filed June 23, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10 1926, to June 22 1927, that I last saw h.. alive on June 22 1927, and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rose A. Greene, M. D.

(Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial June 25 1927

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Hoat St

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23337

CERTIFICATE OF DEATH.

31 E 23337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N Gilmor ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mazzie Addison

(a) RESIDENCE NO. 1022 N Gilmor ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) mch. dec! 1897

7 AGE: Years 30 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto md

(State or country)

PARENTS

10 NAME OF FATHER James Addyson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Bacon

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant (Caroline Milbourne (aunt)

(Address) 1018 N Gilmor

15 Filed 6 23 1927 C. HAMPSON JONES, M. D. Registrar

By R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927

17

I HEREBY CERTIFY, That I attended deceased from March, 1927, to June 21, 1927, that I last saw her alive on June 21, 1927, and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. L. Young, M. D.

6/22/1927 (Address) 1424 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lion

DATE OF BURIAL: 6-25 1927

20 UNDERTAKER: Joseph A Levely

ADDRESS 409 N Front st

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23338

CERTIFICATE OF DEATH.

D4-001

E 23338

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Patapsco ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Perkins

(a) RESIDENCE No. 1416 Patapsco ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen M. Perkins

6 DATE OF BIRTH (month, day, and year) 6-29-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John W. Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Medora Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Perkins (Address) 1416 Patapsco

15 FILED 3 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1927 to June 21st 1927, that I last saw him alive on June 21st 1927, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage.

(duration) May 9/27 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) 1940 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 6/24 1927

20 UNDERTAKER J. Fen McCully

ADDRESS 130 E. Fort

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23339 — 1-PLACE OF DEATH: University Hospital — 179 — E 23339 Registered No.

City of BALTIMORE: (No. Lombard & Green St. 18-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Esa Hawkins

(a) Residence No. 830 Cloney al St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Emil Hawkins

6-DATE OF BIRTH (month, day and year): 1887

7-AGE: 39 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Victoria Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-(Informant): Emil Hawkins

(Address): 830 Cloney St

15-Filed JUN 23 1927 — C. HAMPSON JONES, M. D. Registrar. Per R. H.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6-20-27

17- I HEREBY CERTIFY, That I attended deceased from 6-16 1927 to 6-20 1927

that I last saw her alive on 6-20 1927

and that death occurred, on the date stated above, at 12 59 P. M.

The CAUSE OF DEATH* was as follows:

Acute diffuse nephritis superimposed on a chronic diffuse nephritis

(Duration) Unknown

CONTRIBUTORY (Secondary) Cardiac decompensation

Acute pulmonary oedema

(Duration) hrs. mos. ds.

& Acute Cardiac dilatation

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Esa F Dodgen M. D

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: June 23 1927

20-UNDERTAKER: Samuel H Frush Jr — ADDRESS: 528 N Bond St

Spec. -7-17-26—A Co.—200 Bks.

Turner's

E 23340

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 23340

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO.

City of BALTIMORE: (No.) St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida V. Turner

(a) RESIDENCE NO. 3001 St. Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Chas. H. Turner

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1860

7 AGE	Years	Months	Days	IF LESS than I day hrs. or min.
	66	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housf. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Alex. Hymen (HYMES)

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Prince Geo Co Md

12 MAIDEN NAME OF MOTHER ~~Ida~~ Sturgeon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant (Address) Grace Hospital Record

15 Filed 23 1927 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1927

I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 22, 1927, that I last saw h. alive on June 22, 1927, and that death occurred, on the date stated above, at 5.17 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(doration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6-2-27 6-15-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Tompkins M. D.

. 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 6/24 1927

20 UNDERTAKER Henry W. Spears & Son — ADDRESS 505 N Eutaw

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1420 E. Monument St. 10-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Chaney.

(a) RESIDENCE NO. 1420 E. Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Reginald Chaney

6 DATE OF BIRTH (month, day, and year): August 1897

7 AGE: Years 30 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) June 18, 1927

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Huggins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hue

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Emma Lucas

(Address) 1420 E. Monument St

Filed ..... 19 ..... E. HAMPSON JONES, M. D.

Registrar

JUN 23 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Bacillus infection following an abortion.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) 0

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Heuisler M. D.

(Coroner)

June 18, 1927 (Address) 702 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Rest Date of Burial: June 23 1927

20 UNDERTAKER: Mrs. R. A. Elliott ADDRESS: 1125 Eastland Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23342

10 E 23342

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (Street) 08-64 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur W. Kirby

(a) RESIDENCE No. 4003 Gwynn Oak Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	6	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wilbur Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Gladys Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wilbur Kirby

(Address) 4003 Gwynn Oak Ave

15 Filed JUN 23 1927 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to June 22, 1927, that I last saw him alive on June 22, 1927, and that death occurred, on the date stated above, at 11.20 P m

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos Culture

(Signed) Myron G. Tuell, M. D.

6/23 1927 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL June 23 1927

20 UNDERTAKER Wilbur Schriver ADDRESS 916 Park Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23343

10-00 E·23343

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 533 Cumberland St. 15-21 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hylda B. Sheridan

(a) RESIDENCE NO. 533 Sheridan St. Ward

(Usual place of abode) Cumberland

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~May~~ 10-1919

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	8	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John R. Sheridan

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Magner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amelia Magner

(Address) 533 Cumberland St

15 Filed JUN 23 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/17, 1927, to 6/22, 1927, that I last saw h~~im~~er alive on 6/22, 1927, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

1. Acute Lobar Pneumonia
Contributory?
Intoxication at Close of Masonic Jamboree for Ten days before I was called in.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diphtheria Bacillus Carriers
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Slutty, M. D.

6/23, 1927 (Address) City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial June 23/27

20 UNDERTAKER Daniel Fenton

ADDRESS Penn

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23344

CERTIFICATE OF DEATH.

E 23344
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Harvey

(a) RESIDENCE NO. Cardiff Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 29, 1891

7 AGE: Years 35 | Months 5 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Cardiff Md.

(State or country)

PARENTS

10 NAME OF FATHER: James A. Harvey

11 BIRTHPLACE OF FATHER (city or town): Pa

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town): Pa

(State or country)

14 Informant (Address): Miss Eleanor Harvey Cardiff Md.

15 Filed [illegible] 19 Registrar

JUN 23 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927, to June 23, 1927, that I last saw h.. alive on June 23, 1927, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic peritonitis with bilateral psoas abscesses. Nephritis Chronic

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Psoas abscesses - Chronic Nephritis - tuberculous.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 11, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Murrell T. Shehan, M. D.

6/23, 1927 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cardiff Md. Date of Burial June 23 1927

20 UNDERTAKER: Wm. Thickner Sons ADDRESS North & Pa

Very important: See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 23345

HEALTH DEPARTMENT—CITY OF BALTIMORE

131

E 23345

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Josephs Hospital St. 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Green

(a) RESIDENCE NO. 1733 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen A. Keagle

6 DATE OF BIRTH (month, day, and year) Dec 18 - 1863

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
63	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General natore of industry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Greene

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Helen A Greene

(Address) 1733 N Bond St

15 Filed JUN 23 1927 16 H. HAMPSON JONES, M. D. Registrar

Ret

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to June 22, 1927, that I last saw h[illegible] alive on June 22, 1927, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Inguinal abscess as result of a sloughing chronic Pt Pyonephrosis

(duration) yrs. 14 weeks

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at piece of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Clement R. Bonner M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — Date of Burial June 25 1927

20 UNDERTAKER D. John Ellrich — ADDRESS 2008 Orleans

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23346

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 118-001

E 23346

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. 8-16 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Krieder

(a) RESIDENCE NO. 2113 E. North Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 – 1887

7 AGE: Years 40 — Months 4 — Days 34 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Henry Krieder

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Barbara Hohlind

BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

Informant Mr August Krieder

Address) 1916 E Pratt St

ed 19

Registrar

C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 , 1927, to June 22 , 1927.

that I last saw h e alive on June 22 , 1927

and that death occurred, on the date stated above, at 4 35 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/4/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Smith M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial June 25 1927

20 UNDERTAKER John Ellerick — ADDRESS 2808 Erdman

Cert. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23347

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 90

City of BALTIMORE: (No. 645 Forrest [illegible] St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius C. Wohler

(a) RESIDENCE NO. 645 Forrest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Wohler

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1879

7 AGE Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
48	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Fredk. A. Wohler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilda Klott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Chas. J. Wohler

(Address) 2041 Wilhelm St.

15 Filed JUN 23 1927

16 H. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1927, to June 21, 1927, that I last saw h[illegible] alive on June 20, 1927, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death? Yes Date of May 15/27

Was there an autopsy? -no-

What test confirmed diagnosis?

(Signed) Gustav Dill, M. D.

1927 (Address) 1509 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial June 24, 27

20 UNDERTAKER Chas. W. Dill ADDRESS 3109 Fredk Ave.

Spec.—1-10-21—M&T—1500 Bks.

Jett.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23348 H A Kelly Hosp

CERTIFICATE OF DEATH.

1-59-003 E 23348

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Eutaw Place St., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude F Jett

(a) RESIDENCE NO. Reedville Va ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-1922

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
5	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reedville Va

PARENTS

10 NAME OF FATHER Joseph Jett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Reedville Va

12 MAIDEN NAME OF MOTHER Mabel Mary Reedville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Joseph Jett. (Address) Reedville Va

15 Filed 2-3 1927 C. HAMPSON JAMES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16 1927 to June 22 1927.

that I last saw h alive on June 22. 1927.

and that death occurred, on the date stated above, at 9 Pm

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Enterplay of Bladder

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 17-1927

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Malcolm Hecht M. D.

(Address) 6-22-27. 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Princeton Va

DATE OF BURIAL June 24th 1927

20 UNDERTAKER Bateman & Gore

ADDRESS 1723 W Lafayette Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23349

E 23349

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2004 N. Lafayette Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Hannell

(a) RESIDENCE NO. 2004 N Lafayette Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Chas A. Hannell

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 54 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 237

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: Theodore Renner

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Kirchmeyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Agnes Hannell

(Address): 2004 N Lafayette Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/21 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/19, 1927, to 6/21, 1927, that I last saw h[illegible] alive on 6/21, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows: Uraemia Coma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Exam

(Signed) Chas A Coffin, M. D.

6/21, 1927 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery — Date of Burial: 6/24 1927

20 UNDERTAKER: Chas. F. Evans Son — ADDRESS: 1811 W. Mt. Royal

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23350

CERTIFICATE OF DEATH.

124 E 23350

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 14 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Rosenthal

(a) RESIDENCE NO. 1622 Linden Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Rosenthal

6 DATE OF BIRTH (month, day, and year): Sept. 7, 1850

7 AGE — Years: 76 Months: 9 Days: 15 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Louis Weisenbad

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Kacie Bar

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: John J. Rosenthal

(Address): 1622 Linden ave.

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22- 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-18- 1927, to 6-22 1927,

that I last saw her alive on 6-22- 1927,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall bladder

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): P.O. Obstruction + Myocardial Failure (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-18-27.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Abram J. Rechnitz, M. D.

6-22, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. Date of Burial 6/24/1927

20 UNDERTAKER: Harid Sondheim ADDRESS 18 20 N. Royal Ave

1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23351

CERTIFICATE OF DEATH.

E 23351

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE (No.) Church Home & Infirmary Ward

2-FULL NAME Gilbert Grant Minier

(a) RESIDENCE NO. 2112 Chelsea Terrace St. Wadsworth Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie A. Minier

6 DATE OF BIRTH (month, day, and year): Aug 3-1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Furniture Designer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Penca

(State or country) Cuba

PARENTS

10 NAME OF FATHER: Samuel Cooper

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Nellie A. Minier

(Address) 2112 Chelsea Terrace

C. HAMPSON JONES, M. D.

3 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 23-1927

17 I HEREBY CERTIFY, That I attended deceased from June 13 19 27, to June 23, 19 27, that I last saw him alive on June 23, 19 27, and that death occurred, on the date stated above, at 9:35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma & Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - Metastasis: Pelvic Glands

Chronic Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gilbert G. Minier M. D.

, 19 (Address) Church Home Infirmary,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gathedral Cemetery Date of Burial 6/27 19 27

20 UNDERTAKER: Chas. P. Trawerson ADDRESS 118 W. Mt. Royal Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23352

CERTIFICATE OF DEATH.

31 E 23352

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1611 Abbott St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1611 Abbott St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virgil Johnson

6 DATE OF BIRTH (month, day, and year) May 16/1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
33	32	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ks Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town)_____
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____
(State or country)

14 Informant Virgil Johnson
(Address) 1611 Abbott

3 1927 19 C. HAMPSON JONES, M. D.
Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

(Signed) J. H. Kelly M. D.
(Coroner)

19 6/23/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millers S. C. Date of Burial June 23 27

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1-5 Ashland Ave

Very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.—200 Bks.

E 23353

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23353

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1004 S Curley St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexandra Nowicka

(a) RESIDENCE NO. 1004 S Curley St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 20 27

7 AGE: Years — Months — Days 2 3 — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Felix Nowicki

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Ewa Wisniewska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Felix Nowicki

(Address): 1004 S Curley St

15 Filed: JUN 23 1927

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to June 22, 1927,

that I last saw her alive on June 22, 1927,

and that death occurred, on the date stated above, at 7 41 m.

The CAUSE OF DEATH* was as follows:

Atelectasis neonatorum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. B. Bronushas M. D.

6-23-1927 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. — Date of Burial: June 24 1927

20 UNDERTAKER: Stephen J. Filkowski — ADDRESS: 1006 S Kenwood Ave

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23354

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23354

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Mt. Bolton ST., 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence H. Burnett

(a) RESIDENCE NO. 1904 Mt. Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George P.

6 DATE OF BIRTH (month, day, and year): Oct 15-1855

7 AGE: Years 71 | Months 8 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Nichols B. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md

12 MAIDEN NAME OF MOTHER: Tipsy A Boulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: Isabell Holland

(Address) 1904 Mt Bolton

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

6-25-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/22/ 1927

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1927, to June 22, 1927, that I last saw h[illegible] alive on June 22, 1927, and that death occurred, on the date stated above, at 525 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Nephritis Sclerosis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. S. Love, M. D.

6/25, 1927 (Address) 836 W. Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Spring Cemetery

DATE OF BURIAL: 6/25 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Mt

Spec.-7-17-26—A Co.—200 Bks.

E 23355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43

E 23355

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Fader

(a) RESIDENCE NO. 628 N. Maderia st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1883

7 AGE 43 Years 8 Months 2 Days 44

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Fader

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Minnie Baker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 29, 19 27, to June 22, 19 27,

that I last saw him alive on June 22, 19 27,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of floor of mouth

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. S. Mathews M. D.

6-22-1927 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

Date of Burial 6/24 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mt.

Very Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Sankez)

E 23356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) Fayette & Calhoun Sts. (Ward) 9th Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Daniel Sanchez.

(a) RESIDENCE NO. Welch. W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: about 37 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unknown

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): unknown

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Franklin Sqr Hosp Records

15 Filed JUN 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-22 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/16/27, 19, to 6/22/27, 19,

that I last saw him alive on 6/22/27, 19,

and that death occurred, on the date stated above, at 9 32 m.

The CAUSE OF DEATH* was as follows:

Stricture of Colon at splenic flexure.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction 6/16/27 to 6/22/27

18 Where was disease contracted if not at place of death?

Did an operation precede death? 6/22/27

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) W Wallace Walker M. D.

, 19 (Address) Franklin Square Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Welch West Va

DATE OF BURIAL: June 25 1927

20 UNDERTAKER: Robert Brookerson.

ADDRESS: Corner Calhoun Hollins

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23357

CERTIFICATE OF DEATH

90 E 23357

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1715 E Lombard St. Ward 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Jackow

(a) RESIDENCE NO. 1715 E Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ludwig

6 DATE OF BIRTH (month, day, and year): Feb 5 1841

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	86	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER George Henry

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Smickath

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Catherine Jackow

(Address) 37 S Smallwood St

15 Date received: JUN 23 1927

16 Registrar: C. HAMPSON JONES, M. D.

17 Deputy Registrar: M. L. S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12 1927 to June 22 1927

that I last saw h alive on June 22 1927

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yr. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. L. Rupp M. D.

1927 (Address) 2028 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: June 25 1927

20 UNDERTAKER: Wendell Oppelt & Son

ADDRESS: Baltimore

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23358

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23358

CERTIFICATE OF DEATH

121

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marie Kilkowski

(a) RESIDENCE NO. 103 South Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S. if of foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Thomas —

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed JUN 23 1927, 19 C. HAMPSON JONES, M.D. Registrar

By ALKW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to June 22, 1927, that I last saw h[illegible] alive on June 22, 1927, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and insufficiency.

Pyelonephritis & nephrosis (left)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? gen'l & Laboratory

(Signed) [redacted], M. D.

19 (Address) June 23 1927

BALTIMORE CITY HOSPITALS

*State the [redacted] Violent Causes, state (1) Means and Nature of Injury; [redacted] Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross Cem	June 25 1927

20 UNDERTAKER Kendall & Sisselakm ADDRESS 2128 Eutaw St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23359

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 8
10-008

E 23359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 7-44 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith D. Ehrhardt-

(a) RESIDENCE NO. 53 E. Hamilton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John G. Ehrhardt-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Edith E. Detzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edith E Ehrhardt-

(Address) 53 E Hamilton ave

15 3 1927 By C. HAMPSON JONES, M. D. 19 Per R H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to June 22, 1927, that I last saw her alive on June 22, 1927, and that death occurred, on the date stated above, at 9 40 P m.

The CAUSE OF DEATH* was as follows:

Nasal & Pharyngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Cult.

(Signed) Myron G. Sulle, M. D.

6/23, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL June 27th 27

20 UNDERTAKER Frederick Leadmon Sons Fullerton

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

Martin Mach ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23360

E 23360

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 719 S. Ibard ST. 24 WARD)

2-FULL NAME martin mach

(a) RESIDENCE NO. 719 S. Ibard ST. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	months	mthy	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) Country Service

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Mach (Address) 1927 Gough St

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1927, to June 22, 1927, that I last saw h in alive on June 22, 1927, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy 24 hrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Angina

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cardiac trouble

(Signed) H. Swindell Brit M. D.

23. 6. 1927 (Address) 2042 Gardner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus DATE OF BURIAL: June 25 1927

20 UNDERTAKER: John W Weber ADDRESS: 1803 Bank

How is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23361

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23361

CERTIFICATE OF DEATH.

162

1. PLACE OF DEATH 1033 N Bond St. REGISTERED NO. 7-13

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Bernard Krabbe.

(a) RESIDENCE NO. 1033 N Bond St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-27.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 200

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Krabbe.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Hardy.

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country) Md.

14 Informant Bernard Krabbe.
(Address) 1033 N Bond St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-1927

17 I HEREBY CERTIFY, That I attended deceased from 6-21, 1927, to 6-23, 1927.

that I last saw him alive on 6-23, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Malleus

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ..... unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Hampson Jones M.D.

6/27, 1927 (Address) 800 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL June 24 '27.

20 UNDERTAKER Martin Fahey & Son

ADDRESS 1827 N Monroe

Spec.—1-12-23—M&T—500 Bks.

E 23362

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23362

CERTIFICATE OF DEATH.

129 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Miller ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bundy

(a) RESIDENCE NO. 1625 Miller ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emma Bundy

6 DATE OF BIRTH (month, day, and year) 8-8-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	62	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co. (State or country) Va

PARENTS

10 NAME OF FATHER Rivin Bundy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Bundy.

(Address) 1625 Miller

15 Filed JUL 4 1927, 19 C. HAMPSON JONES, M. D. Registrar

By R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21- 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-27-, 1927, to 6-21-, 1927, that I last saw h in alive on 6-21-, 1927 and that death occurred, on the date stated above, at 7,45 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) Last Known yrs. mos ds.

CONTRIBUTORY (Secondary) Cortico - sclerosis

(duration) Last Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Barger, M. D.

6-22-1927 (Address) 611 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL 6/24/27

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

E 23363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-002 E 23363

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Division St ST. 14-20 WARD)

2-FULL NAME James Wilbert Henry. Jr.

(a) RESIDENCE No. 1410 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16/26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James W. Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Agnes Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Agnes Henry

(Address) 1410 Division St

15 Filed 6 24 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 22, 1927, that I last saw him alive on June 21, 1927, and that death occurred, on the date stated above, at 2.05 A m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Spinal Meningitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? L P

(Signed) Dr Gill Bernard, M. D.

6-23 1927 (Address) 108 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lidiny — DATE OF BURIAL 6/24/27

20 UNDERTAKER Mrs. R. G. Elbert — ADDRESS 725 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23364

CERTIFICATE OF DEATH.

197 E 23364

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute St Joseph Hospital 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilmer Rich

(a) RESIDENCE NO. 1321 Brunt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Rich

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U

12 MAIDEN NAME OF MOTHER U

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) U

14 Informant Lucy Rich

(Address) 1321 Brunt St

15 Filed JUN 24 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 June 19/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Pistol Shot thru heart

Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

6/23/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Date of Burial June 24/1927

20 UNDERTAKER Dennis Carbin ADDRESS 516 Pine

C. HAMPTON JONES, M. D.

Spec—12-23-21—F.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23365

CERTIFICATE OF DEATH.

161-901 E 23365

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital Ward 36)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Boy Pyles.

(a) Residence No. 617 Cleveland Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 3/4 hrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Infant.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 21, 1927.

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 5 hrs. or 1/5 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore

(State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Lloyd Pyles.

11-BIRTHPLACE OF FATHER (city or town). (State or Country). West Virginia

12-MAIDEN NAME OF MOTHER. Ellen Harpster

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Pennsylvania

14- (Informant). Lloyd Pyles

(Address). 617 Cleveland Ave.

15- Filed. JUN 24 1927 Registrar. R. HAMPTON JONES, M. D. UNIVERSITY OF MARYLAND

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21, 1927

17- I HEREBY CERTIFY, That I attended deceased from June 21, 1927 to June 21 1927

that I last saw him alive on June 21 1927

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Prematurity and Maternal Pre-eclamptic toxemia

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Margaret B. Ballard M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER. ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 23366 REGISTERED NO. E 23366

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 W. Gorm. 22-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Rich

(a) RESIDENCE NO. 12 W. Gorm - St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip Rich

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE — Years: 57 — Months: — — Days: — — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Rose Bailey

(Address): 12 W. Gorm St

15 Filed JUN 27 1927 H. Gibson Jones M. D. Registrar

RKR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 1927, to 6/22, 1927, that I last saw her alive on 6/21, 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Chr Nephritis (duration) yrs. (chronic) mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? clinical + + +

(Signed) Dan Trumbo M. D.

6/22 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — Date of Burial: June 24 1927

20 UNDERTAKER: D. L. Brown & Son — ADDRESS: 117 N. Eutaw St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

Dr Smith Frank & Perring Co

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23367

E 23367

CERTIFICATE OF DEATH.

15-21

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 N Pulaski St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmidt

(a) RESIDENCE NO. 2107 N Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Schmidt

6 DATE OF BIRTH (month, day, and year): Dec 4 1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
75	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis Bush.

(Address) 205 Clifton Ave

15 Filed JUN 24 1927 C. HAMPSON JONES, M.D. Per CRK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1927

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 22, 1927, that I last saw him alive on June 23, 1927, and that death occurred, on the date stated above, at 4.15 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobaris, 14 days ago.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Imbecility 10 days

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) Elsmith M. D.

6/28 1927 (Address) 1600 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 27 1927

20 UNDERTAKER: Jos Cook — ADDRESS: 507 E Monument

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23368

CERTIFICATE OF DEATH

161-601

E 23368

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 933 S Sharp St. 23-31 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brockington

(a) RESIDENCE NO. 933 S Sharp St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 6/19/27

7 AGE: Years — Months — Days: 3 4 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): md

PARENTS

10 NAME OF FATHER: Edw. Brockington

11 BIRTHPLACE OF FATHER (City or town)

(State or country): S.C.

12 MAIDEN NAME OF MOTHER: Sallie Spicer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Dodie Spicer Brockington

(Address): 933 S Sharp St.

15 Filed JUN 24 1927, 19 — Registrar: RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/19 1927 to 6/23 1927.

that I last saw h— alive on 6/22 1927.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Contracted Pelvis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dan Morley M. D.

6/25 1927 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — Date of Burial: June 24 1927

20 UNDERTAKER: J. H. Brown & Son — ADDRESS: [illegible]

C. J. THOMPSON, DEPUTY REGISTRAR

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

Charles B. Brigerman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23369 — 31 E 23369

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2435 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Brigerman

(a) RESIDENCE NO. 1438 Hanbut St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norma Zeigler

6 DATE OF BIRTH (month, day, and year) Jan. 3. 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	37	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George S Brigerman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Abby Dickson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 BALTIMORE CITY HOSPITALS

(Address) [redacted] Dept.

15 Filed JUN 24 1927, 19

Registrar R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 23, 1927,

that I last saw h.im alive on June 22, 1927,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Obstruction

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & Laboratory

(Signed) [redacted] M. D.

June 23 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: June 27 1927

20 UNDERTAKER: Chas. L. Stevens. — ADDRESS 1901 E Fort Ave

Very important. See instructions on back of certificates. Insert number of OCCUPATION IS

Spec.—12-9-25—A Co.—200 Bks.

Susan F. Beverley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23370

CERTIFICATE OF DEATH.

X 60-002 E 23370

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 6th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susan Faulkner Beverley

(a) RESIDENCE NO. 423 W. Leicester St. _____ Ward Winchester, Va.

(Usual place of abode)

Length of residence in city or town where death occurred ~~each~~ mos. 11 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	White	married

5a If married, widowed, or divorced ~~Husband of~~ (or ~~wife~~) of J. Gray Beverly

6 DATE OF BIRTH (month, day, and year) March 16th 1891

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	36	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Va.

PARENTS

10 NAME OF FATHER Isaac Faulkner

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Va.

12 MAIDEN NAME OF MOTHER Belle Giffen

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Va.

14 Informant J. Gray Beverley

(Address) Winchester, Va.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MAR 1927

Via B. & O. R.R. - J. Gray Beverley & Escort

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 23

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1927, to June 23, 1927, that I last saw her alive on June 23, 1927, and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction with myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) adenoma of thyroid and myocardial failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 11, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) R. Clark Eyrich, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester, Va. Date of Burial 6/24 1927

20 UNDERTAKER Henry W. Ellers & Son ADDRESS 805 N. Calvert St.

Spec.—1-12-23—M&T—500 Bks.

E 23371 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23371

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH 2009 Ashton St REGISTERED NO. 20-28

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Romm

(a) RESIDENCE NO. 2009 Ashton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3-27

7 AGE	Years	Months	Days 20	If LESS than 1 day, hrs or min.
	—	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Elmer Romm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma Otto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elmer Romm

(Address) 2009 Ashton St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to June 23, 1927, that I last saw him alive on June 23, 1927 and that death occurred, on the date stated above, at 1 P m

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 7 days

CONTRIBUTORY (Secondary) Emaciation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Phy.

(Signed) Fred T. Kyser M. D.

, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 24 1927
20 UNDERTAKER George L. Schwatt	ADDRESS 401 Druid Ave

Spec.–7-17-26–A Co.–200 Bks.

E 23372

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 E 23372

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 718 n Carrollne St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Parker

(a) RESIDENCE NO. 718 n Carrollne St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 Color or Race: Black Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25, 1900

7 AGE Years: 26 Months: 8 Days: 26

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Md

9 BIRTHPLACE (city or town):

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Parker

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Linnie Chase

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Wm H. Chase

(Address) 1811 E. Madison St.

15 Filed JUN 24 1927 19 Per K K Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927 to June 21, 1927.

that I last saw h[illegible] alive on June 21, 1927.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6-22-1927 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Date of Burial: June 24 1927

20 UNDERTAKER: Samuel Hensley ADDRESS 578 N Eddale

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23373

CERTIFICATE OF DEATH.

185 E 23373

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2238 Guilford Ave St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Barry

(a) RESIDENCE NO. 2238 Guilford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred: 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Cronin Barry

6 DATE OF BIRTH (month, day, and year) Nov 19/1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER David Barry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gamon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Nora Cronin Barry

(Address) 2235 Guilford Ave

15 Filed JUN 24 1927 C. HAMPSON JONES, M. D. Registrar

Per R K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jun 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Abcessed Rt Lung

(duration) yrs. mos. ds.

(Signed) J. H. Pue, M. D.
(Coroner)

6/23/27 (Address) 508E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial June 25 1927

20 UNDERTAKER Mary M. Wiedefeld ADDRESS 509 E 22 St

Very important. See instructions on back of certificate. OCCUPATION IS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23374

CERTIFICATE OF DEATH.

1827 E 23374

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St., 8 Ward)

2-FULL NAME Dudley Wilson

(a) RESIDENCE NO. 2009 E. Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	16	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper at

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Training

(c) Name of employer School

9 BIRTHPLACE (city or town)

(State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Stewart Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Clara Cox

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annapolis Md

14 Informant Mrs. Edward Maguire

(Address) 2009 E. Lafayette Ave.

15 Filed 1927 19 C. HARRISON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) G E Wades M. D.

(Coroner)

June 23/27 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial June 25 1927

20 UNDERTAKER Henry Lutz ADDRESS 1203 N Broadway

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23375

CERTIFICATE OF DEATH.

1927 E 23375

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Mercy Hospital St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph McDonald.(C)

(a) RESIDENCE NO. 1811 Maryland Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	----	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. C.D.

(Address) C. HAMPSON JONES, M. D.

15 4 1927 Per_____ 19____ Registrar

1483

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and laceration of the brain. Having been struck on the head by a hammer. Homicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner)

6/22 19 27 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

1811 Maryland Ave. June 12, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23376

66 E 23376

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) On the way to Mercy Hospital. St. 4-30 Ward)

2-FULL NAME Joseph Bell.(C)

(a) RESIDENCE NO. 412 Orange Court. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Do not know.

14 Informant Covenia Washington.(C)

(Address) 412 Orange Court.

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. mos. ds.

(Signed) Otto Leonhardt M. D.

(Coroner)

6/22 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Pier 8 Pratt st. June 15, 1927

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

C. HAMPSON JONES, M. D.

1484

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 23377

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23377

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH Belvieu Manchester apts REGISTERED NO.

CITY OF BALTIMORE: (No. Belvieu & Modesin ave ST., 11th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rabary Wife

(a) RESIDENCE NO. Belvieu Manchester apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther Wife.

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Goddard Rabary

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Luther Wife (Address) Manchester apts

Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY That I attended deceased from May 31 1927 to June 24 1927.

that I last saw h[illegible] alive on June 24 1927.

and that death occurred, on the date stated above, at 8 30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Right side)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. P. Clautice M. D.

(Address) June 24, 1927 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cemetery DATE OF BURIAL June 27 1927

20 UNDERTAKER Eckhardt & Yoe ADDRESS 1723 N. Eutaw St

Spec.—1-10-21—M&T—1500 Blks.—Important: See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23378

REGISTERED NO. 29 E 23378

1-PLACE OF DEATH

City of BALTIMORE: (No. 3240 Tait ave. St., 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Kampschulte

(a) RESIDENCE NO. 3240 Tait ave. St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Catharine Kampschulte

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1840

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	86	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Robert.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Knoch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary A. Fiese (Daughter)

(Address) 3240 Tait Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1926, to June 21, 1927, that I last saw h[illegible] alive on June 21, 1927, and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic ulcerative Cystitis

(duration) ..... yrs. 10 mos 21 da.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos 10 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

Date of Burial June 25th 1927

20 UNDERTAKER Lilly + Geiler

ADDRESS 403 S Wolfe St

4 1927

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

E 23379

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Marine Hospital No 1. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore, Md ST. 26-1 WARD)

2-FULL NAME John C Selig.

(a) RESIDENCE NO. 519 S. Ann ave ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Unknown

6 DATE OF BIRTH (month, day, and year) Feb 14, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	43	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Tug Porter

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER C. Selig

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Echert

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Self.
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to June 22, 1927, that I last saw h in alive on June 22, 1927 and that death occurred, on the date stated above, at 4:02 A m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
Resulting from rupture of
gastric ulcer

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Ruptured Gastric Ulcer

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Baltimore - home

Did an operation precede death? yes Date of June 18 1927

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C K Wilmot M.D. M. D.

June 22 1927 (Address) U.S Marine Hospital, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL June 25 1927

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23380

CERTIFICATE OF DEATH

145-001

E 23380

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Womans Hospital St., 1-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Sullivan Orendorff

(a) RESIDENCE NO. 829 Cator Ave St. Ward

(Usual place of abode) (If non-resident giva city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Birmingham Orendorff

6 DATE OF BIRTH (month, day, and year) — 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Patrick L. Sullivan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Jennie Brice

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carrol Co. Maryland

14 Informant Husband.

(Address) 829 Cator Ave.

15 Filed , 19 Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1927, to June 23, 1927, that I last saw her alive on June 23, 1927, and that death occurred, on the date stated above, at 7 05 P. m.

The CAUSE OF DEATH* was as follows:

Cesarean section - (Commenced before onset of labor)

Im pregnancy, (duration) yrs. mos. ds.

CONTRIBUTORY Pleuritic effusion

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 6-15-27.

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory laparotomy 6-15-27

(Signed) Edward H. Richardson M. D.

, 19 (Address) Womans Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 6/25 1927

20 UNDERTAKER J. Kemp Bowers

ADDRESS 3322 Gw Ave

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

(Baroneski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23381

100-901

E 23381

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., BALTIMORE CITY HOSPITALS Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seimira Baranowski

(a) RESIDENCE NO. 624 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	80 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed 6-24 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21/1927

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 21, 1927

that I last saw her alive on June 21, 1927

and that death occurred, on the date stated above, at 11.00 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. 7 mos. 3 ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Exam

(Signed) R. H. Smith, M. D.

. 19 (Address) BALTIMORE CITY H[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Point Cem 6/25 1927

Date of Burial

20 UNDERTAKER J. F. Dahlgreen

ADDRESS 1318 Light St

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 23382

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 E 23382

CERTIFICATE OF DEATH.

1-PLACE OF DEATH On the way to the

City of BALTIMORE: (No. South Baltimore General Hospital) 2526

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard M. Lambeth.

(a) RESIDENCE NO. 4th St, nr 2nd Ave. Fairfield. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXXXXXX XXXXXXXX Minnie Lambeth.

6 DATE OF BIRTH (month, day, and year) March 18, 1869.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Minnie Lambeth. (wife)

(Address) 4th St. nr. 2nd Ave. Fairfield.

15 Filed 6 24 1927 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of the Brain.
Pistol shot wound in the mouth.
Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto R. Eisenhardt M. D.
(Coroner)

6/22 19 27 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 4th St nr. 2nd Ave. Fairfield. June 22, 27

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 6/25 1927

20 UNDERTAKER L. P. Lahmeyer & Sons ADDRESS 1918 Pitts Ave

WRITE PLAINLY. Certificate should be carefully filled out. DEATH in pencil. Read very important. See instructions on back of certificate. LAST STATEMENT OF OCCUPATION IS

Spec.—1-10-21—M&T—1500 Bks.

E 23383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23383

CERTIFICATE OF DEATH.

101-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanitarium 15-61 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Parkman Ward

(a) RESIDENCE NO. 3516 Forest Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

~~S. Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruth V. Ward

6 DATE OF BIRTH (month, day, and year): Aug 31-1890

7 AGE: Years 36 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Bakery Supplies

(c) Name of employer: E. E. Riddle

9 BIRTHPLACE (city or town) (State or country): Londora Md.

PARENTS

10 NAME OF FATHER: Clifton P. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Emily Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Ruth V. Ward 3516 Forest Park Ave

15 Filed 5 1927 C. HAMPSON JONES, M. D. Registrar

By ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5 , 1927 , to June 24 , 1927 ,

that I last saw h in alive on June 24 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wheaton, M. D.

, 19 (Address) 4309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL: June 27 1927

20 UNDERTAKER: Pedtram & Lore ADDRESS: 1723 N. Charles St

THIS IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Robinson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23384 — 91-902 — E 23384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 701 W Lanvale St. 4-16 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Robinson

(a) RESIDENCE NO. 701 W Lanvale St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE C

5 ~~Single, Married,~~ Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Robinson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE 63 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. Swan, Contractor

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Rivers (Address) 701 Lanvale St

15 Filed JUN 5 1927 G. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to June 22, 1927, that I last saw him alive on June 20, 1927, and that death occurred, on the date stated above, at 9.50 A.M.

The CAUSE OF DEATH* was as follows: Senile Decay

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Degeneration Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Maxwell Stuart M. D.

, 19 (Address) 1300 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery — DATE OF BURIAL June 24 1927

20 UNDERTAKER Eugene Waters — ADDRESS 423 Fremont Ave

FROM is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23385

CERTIFICATE OF DEATH.

23 E 23385

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 16 Ward)

2-FULL NAME Bertha Yeager

(a) RESIDENCE NO. 1401 N. Ellington Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16. 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	41	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert J Yeager

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth J Amick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Sophie M Yeager

(Address) 1401 N Ellington Ave

15 Filed G. HAMPSON JONES, M. D.

5 1927 By SHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 8 1927, to June 24 1927,

that I last saw her alive on June 24 1927,

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death! Home

Did an operation precede death! Yes Date of April 8 1927 (Appendicitis)

Was there an autopsy! Yes

What test confirmed diagnosis!

(Signed) Vernon H. Norwood, M. D.

June 27 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial June 27 1927

20 UNDERTAKER J H Cook ADDRESS 507 E North Ave

Key important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23386 46 E 23386

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 6-10 Ward)

2-FULL NAME Mrs Bessie Webster

(a) RESIDENCE NO. 429 N. Luzerne St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Webster

6 DATE OF BIRTH (month, day, and year) Oct. 28/1881

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
45	7	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. W. Windsor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah V. Webster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Harry Webster

(Address) 429 N. Luzerne ave

15 Filed ..... 19 .....

JUN 3 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 6-23-

17 I HEREBY CERTIFY, That I attended deceased from 6-22 1927, to 6-23 1927, that I last saw her alive on 6-23 1927, and that death occurred, on the date stated above, at 1230 P.M.

THE CAUSE OF DEATH* was as follows:

Carcinoma of uterus (cervix)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-23-27

Was there an autopsy? no

What test confirmed diagnosis? Microscope.

(Signed) Emil Novak, M. D.

June 24 1927 (Address) 26 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem Date of Burial June 27 1927

20 UNDERTAKER J. J. Kerr & Son ADDRESS 156 N. Luzerne

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23387

CERTIFICATE OF DEATH

113 E 23387

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 722 S Bond St St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Godlewska

(a) RESIDENCE NO. 722 S Bond St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Stanislaus Godlewska

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Walerza Domino

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Stanislaus Godlewska

(Address) 722 S Bond St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

5 1927 Per RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 27, to June 24, 19 27,

that I last saw h alive on June 24, 19 27,

and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Enteritis

Toxic Nature, Cause Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic, Complicated by Acute Bronchitis.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr. M. D.

6/28, 19 (Address) 1500 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary June 25 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bond St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23388

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23388

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 509 Woodlawn ave. Roland Park ST. (WARD)

2-FULL NAME David Preston Byers

(a) RESIDENCE. NO. 509 Woodlawn Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 20 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clothing Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connellsville Pa.

PARENTS

10 NAME OF FATHER Wellington Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville Va.

12 MAIDEN NAME OF MOTHER Mary E. Peers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Horace W. Byers Nephew
(Address) 509 Woodlawn Rd

15 Filed JUN 25 1927 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1926, to 24 June, 1927, that I last saw h im alive on 24 June, 1927, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Consultations & Tests

(Signed) Horace W. Byers, M. D.

, 19 (Address) 214 W. Monument ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlotte North Carolina — DATE OF BURIAL: June 27 1927

20 UNDERTAKER: Chas. S. Black — ADDRESS: 142 W Worth Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23389 E 23389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Druid Hill Av ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Glascoe

(a) RESIDENCE NO. 1624 Druid Hill Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Katie Glascoe

6 DATE OF BIRTH (month, day, and year) — — 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture mover

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pr. George Co Md

12 MAIDEN NAME OF MOTHER Sallie Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pr. George Co Md

14 Informant Katie Glascoe

(Address) 1624 Druid Hill Ave

15 Filed JUN 1927, 19 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 7, to June 23, 1927, that I last saw h[illegible] alive on June 23, 1927, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) High Pressure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chis. M. D.

6/24 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 6/27/1927

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1624 Druid Hill

Cor.—12-9-25—A Co.—200 Bks.

E 23390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

184-003 E 23390

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Brown

(a) RESIDENCE NO. 421 E. Penna Ave Towson Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Mar 2/1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
13	12	3	20 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Student

(b) General nature of industry, business, or establishment in which employed (or employer) O K

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Brown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Va

12 MAIDEN NAME OF MOTHER Nellie Britian

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md

14 Informant Nellie Brown

(Address) Towson Md

15 June 19 27 C. HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock- Leg crushed by autotruck York Road nr Willow Ave., Towson Md

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....

(Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Cox, M. D.

(Coroner)

19 6/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abington, Md Date of Burial 6/26/1927

20 UNDERTAKER Mrs Geo. H. Holland ADDRESS 1631 Druid Hill

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

See letter in file 8/16/27.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23391

CERTIFICATE OF DEATH

E. 23391

31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Davis

(a) RESIDENCE NO. 507 Roberts st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	~~Married~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Davis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Cressen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

2339 1927

NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to June 23, 1927, 19

that I last saw him alive on June 23, 1927, 19

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Cullen M. D.

6-24-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 6/27/1927

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1831 Druid Hill

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23392

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23392

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 179

City of BALTIMORE: (No.) St. 20-27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Mann.

(a) RESIDENCE NO. Home for aged St. Fulton and Franklin Sts Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1865

7 AGE — Years: 61 Months: 8 Days: 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home for aged

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER John Mann

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Newton

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country)

14 Informant (Address)

15 Filed JUN 5 1927, 19 C. HAMPSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/23/27, 19 , to 6/24, 19 27.

that I last saw h[illegible] alive on 6/24, 19 27.

and that death occurred, on the date stated above, at 9:00 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

? 8 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY Anemia

(Secondary)

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 Address Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — Date of Burial: June 9 1927

20 UNDERTAKER: George J. Smith — ADDRESS: Hollins

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23393

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1119 E. North ave. Ward) 4-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Higgins.

(a) RESIDENCE NO. 1119 E. North ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Higgins.

6 DATE OF BIRTH (month, day, and year): Dec. 28th 1861

7 AGE: Years 65 | Months 5 | Days 25 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police.

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Higgins

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Maryann Arnold

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland.

14 Informant: Mrs. Mary E. Higgins

(Address): 1119 E. North ave.

15 Filed: 1927 C. H. THOMPSON JONES, M. D.

Per ACB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 23 - 1927

I HEREBY CERTIFY, That I attended deceased from Sept 15 1927, to June 23, 1927, that I last saw h[illegible] alive on June 22, 1927 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rectum

(duration) yrs. 10 mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Kirby, M. D.

(Address) 1106 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial June 27 1927

20 UNDERTAKER: E. J. Fanning & Son ADDRESS La Fayette & Wash. Ave.

5 very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23394

90 E 23394

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. 14-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Broadnax

(a) RESIDENCE NO. 514 Stockton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Stockton

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 60 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Catlin's

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant BALTIMORE CITY HOSPITALS

(Address) [illegible]

15 Filed 5 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1926, to June 23, 1927, that I last saw h[illegible] alive on June 23, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening

Myocardial hypertrophy & emphysema

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General observation

(Signed) C. Hampson Jones, M. D.

1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Date of Burial June 27 1927

20 UNDERTAKER Wm. H. Case Sons ADDRESS 1400 Mosher

very important. See instructions on back of certificates.

(Joseph Curtis)

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23395

CERTIFICATE OF DEATH

129 E 23395

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Curtis.

(a) RESIDENCE NO. 924 Woodyear St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Curtis

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town): Indiana

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Forbes -

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mary Curtis 924 Woodyear

15 Filed JUN 25 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-22-27

17 I HEREBY CERTIFY, That I attended deceased from 4-9- 1927 to 6-22- 1927

that I last saw h[illegible] alive on 6-22- 1927

and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Edmund Lyon

(Signed) J. B. Angell M. D.

6 24 1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Olivet St Peters Date of Burial: June 27 1927

20 UNDERTAKER: Wm H Carse Son ADDRESS 1450 Mosher

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23396

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23396

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3004 Belmont Ave (St. or Ave.) 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tillie Ottilie Gruber

(a) RESIDENCE NO. 3004 Belmont Ave (St. or Ave.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Gruber

6 DATE OF BIRTH (month, day, and year): May 2, 1874

7 AGE — Years: 53 — Months: 1 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Casper Nilpert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Mark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Julia O. Lane, 3004 Belmont Ave

15 Filed 6-25-1927, 19 — Per — Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to June 23, 1927, that I last saw h[illegible] alive on June 23, 1927, and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Pulmonary Metastases

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb. 1926

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McCleery, M. D.

6/28, 1927 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 27, 27

20 UNDERTAKER: Wm. Pickerel Sons — ADDRESS: Mordecai Pa

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23397

CERTIFICATE OF DEATH.

129

E 23397

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St. (Ward) 30

2-FULL NAME Henry Boisbut

(a) RESIDENCE NO. Not known St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Cold

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mch 1877

7 AGE: Years 50 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Edmond Bryant

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant J. H. Welton

(Address) Edenton Va

15 Filed June 21, 1927 J H - Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma.

(duration) Yrs. 1 mos. ds.

Signed G C Lentz M. D.

(Coroner)

June 25 19 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lyells Richmond Co. Va. Date of Burial June 25 1927

20 UNDERTAKER C. HAMILTON JONES, M. D. ADDRESS Jan H Tompkins Funeral Director

Very important. See instructions on back of certificate. Last Statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23398 — CERTIFICATE OF DEATH — X 124 — E 23398

1-PLACE OF DEATH Municipal Hospital — REGISTERED NO. ____

CITY OF BALTIMORE: (No. Lombard & Green St., 30 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B Guthrie

(a) RESIDENCE NO. 6 Cumberland St., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 1 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) Oct 3, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	41	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) R.R. 0/3
(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS
10 NAME OF FATHER John D Guthrie
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.
12 MAIDEN NAME OF MOTHER Martha L Davis
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Samuel D Guthrie
(Address) 332 Uttridge Ave

15 Filed 2 6 1927, 19 ____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-21-27, 19 ____, to 6-25-27, 19 ____, that I last saw him alive on 6-25-27, 19 ____, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Arterial Hypertension.
Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Cumberland Md.
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? Chemistry & Clinical

(Signed) N D Hendrix, M. D.
, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths due to violent or unnatural state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Va — DATE OF BURIAL June 26 1927

20 UNDERTAKER Wm Enoch — ADDRESS 507 E Lombard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23399

CERTIFICATE OF DEATH.

90 E 23399

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 546 W. Conway. (St.) 27-30 (WARD)

2-FULL NAME Elizabeth Seibert

(a) RESIDENCE NO. 546 W. Conway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Seibert

6 DATE OF BIRTH (month, day, and year) Sept 11. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kohl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Jacob W. Seibert

(Address) 546 W. Conway St.

15 Filed JUN 26 1927 Registrar C. HAMPSON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to June 23, 1927, that I last saw h e alive on June 22, 1927, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Chr Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) M Dowell, M. D.

June 24, 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 27, 1927

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 201 W. Fayette

Please write very important. See instructions on back of certificates.

Spec.—12 9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23400

CERTIFICATE OF DEATH.

90

E 23400

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Dmon St. 7-1-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Levi

(a) RESIDENCE NO. 921 Dmon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 63 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): 0 170
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Chas Levi

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Scott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Cornelius Levi
(Address): 921 Dmon

15 Filed 6 26 1927 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to June 22, 1927, that I last saw him alive on June 20, 1927, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Nil

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H S McCall, M. D.

6/26 1927 (Address) 1005 Dmid Hilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn. cem. Date of Burial June 26 1927

20 UNDERTAKER: John H Toadvine ADDRESS Druid Hill ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23401

CERTIFICATE OF DEATH

E 23401

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO. 15-21

City of BALTIMORE: (No. Caroline & oliver St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Johnson

(a) RESIDENCE NO. 1711 N mount St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1915

7 AGE 12 Years — Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Howard Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. md

12 MAIDEN NAME OF MOTHER Stella Tasker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. md

14 Informant Stella Tasker Johnson

(Address) 1711 N. mount St

15 Filed JUN 6 1927 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/27 1927

6/23/27 12:15 A.m.

17 I HEREBY CERTIFY, That I attended deceased from 6/21/27, 1927, to 6/23/27, 1927, that I last saw h[illegible] alive on 6/23/27, 1927, and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. mos. 4 ds.

18 Where was disease contracted Home

If not at place of death? Home

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. R. McConnell M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

Date of Burial 6/27 1927

20 UNDERTAKER Thomas E Kelson

ADDRESS 1338 Pitts[illegible] Ave

R. HAMPSON JONES, M. D.

Registrar

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23402 — 1-PLACE OF DEATH — REGISTERED NO. E 23402

City of BALTIMORE: (No. 720 N Patterson Park Ave. — Ward) 7/12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T Jones Jr

(a) RESIDENCE NO. 720 N Patterson Park Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Susan T Jones

6 DATE OF BIRTH (month, day, and year): Mar 13-1850

7 AGE — Years: 77 — Months: 3 — Days: 10 11 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Slate Riner

(b) General nature of Indnstry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Wales Eng

(State or country)

PARENTS

10 NAME OF FATHER: John T. Jones

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Wales Eng

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Not Known

14 Informant: John T Jones Jr

(Address) 720 N Patterson Park Ave

Filed JUN 26 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 23/27

17 I HEREBY CERTIFY, That I attended deceased from June 20 1927, to June 23, 1927, that I last saw him alive on June 23 1927, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen T Simmons, M. D.

June 24 1927 (Address) 718 N Pat Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Ridge Cardiff Hampden — Date of Burial June 26 1927

20 UNDERTAKER: Geo C. Miller & Son — ADDRESS 2334 Jefferson

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23403

CERTIFICATE OF DEATH.

10-003 E 23403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital 10-69 ST., WARD)

2-FULL NAME Frederick O'Bull

(a) RESIDENCE NO. 335 Font Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Schneider O'Bull

6 DATE OF BIRTH (month, day, and year) Jan 25, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	35	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Terms. Life Ins. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas O'Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Hafer?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sarah O'Bull

(Address) 335 Font Hill Ave

15 Filed 6 26 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to June 24, 1927, that I last saw him alive on June 24, 1927 and that death occurred, on the date stated above, at 2 50 P m.

The CAUSE OF DEATH* was as follows:

Nasal, Pharyngeal, & Laryngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of June 24, 1927

Was there an autopsy? No

What test confirmed diagnosis Clinical & pos culture

(Signed) Myron G. Dull, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 6/26/27

20 UNDERTAKER Fredk. C. [illegible]

ADDRESS 941 Hollins

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23404 — 31 E 23404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 S Gilmore (St.) 19-28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luis Salavarda

(a) RESIDENCE NO. 508 S Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1887 June

7 AGE: Years 40 | Months | Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Joseph Salavarda

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Anna Salavarda

(Address) 508 S Gilmore St

15 Filed ....., 19.... R K Registrar

26 1927 C. HAMPSON REES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/23/1927

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1927 to 6-23, 1927

that I last saw h alive on 6-23, 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard Davis, M. D.

, 19 (Address) 1727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 27 1927

20 UNDERTAKER: John J Tilden — ADDRESS: 1200 N Fremont St

Hon. is very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23405

CERTIFICATE OF DEATH.

E 23405

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 E. Fort Ave., ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. Lintline

(a) RESIDENCE NO. 506 E. Fort Ave., ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida E. Lintline

6 DATE OF BIRTH (month, day, and year) June 17, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe-fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Davision Chemical

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard Lintline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Freida Lintline

(Address) 506 E. Fort Ave.

15 Filed JUN 26 1927, 19 C. HAMPSON JONES, M. D. Per R.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 24, 1927, that I last saw h alive on June 23, 1927, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

June 26, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: June 27 1927

20 UNDERTAKER: Nelson E. Stiles — ADDRESS: 231 Md. Ave Westport

FOR A very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

E 23406

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Druid Hill Ave ST.) 47-24 (WARD)

2-FULL NAME Sarah R. Burgess

(a) RESIDENCE NO. 1316 Druid Hill Ave ST.— WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wm R. Burgess

6 DATE OF BIRTH (month, day, and year) —1— 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kilmarnock Va
(State or country)

PARENTS

10 NAME OF FATHER George Lee

11 BIRTHPLACE OF FATHER (city or town) Kilmarnock Va
(State or country)

12 MAIDEN NAME OF MOTHER Bettie Emory

13 BIRTHPLACE OF MOTHER (city or town) Kilmarnock Va
(State or country)

14 Informant Ollie Taylor
(Address) 1316 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23. 1927

17 I HEREBY ~~CERTIFY~~, That I attended deceased from March 14 1927 to June 23 1927,
that I last saw ~~him~~ her alive on June 23 1927,
and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Substernal Goiter

Ma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Arlington Va

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

6/24 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kilmarnock Va

DATE OF BURIAL June 27 1927

20 UNDERTAKER Samuel H. Hensley

ADDRESS 536 N Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23407

CERTIFICATE OF DEATH.

24001

E 23407

1-PLACE OF DEATH DR. WHITE'S HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1029 Madison Avenue ST. 14-23 WARD

2-FULL NAME Joseph Cobb

(a) RESIDENCE NO. 713 Mosher ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Cobb

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

021

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Joseph Cobb

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Celia Cobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Martha Cobb

(Address): 713 Mosher St.

15 Filed JUN 26 1921, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to June 22, 1927.

that I last saw him alive on June 22, 1927

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: June 27 '27

20 UNDERTAKER: Emmert & Bradley

ADDRESS: W. B. Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23408 — REGISTERED NO. 153 E 23408

1-PLACE OF DEATH: South Balto Gen Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1211 Light St. Ward) 11-24

2-FULL NAME: Alice Ramsay

(a) RESIDENCE NO. 235 W Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE — Years: 47 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): N.C.

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Dont Know.

14 Informant: J. W. Alstin

(Address): 235 W Biddle St.

15 FILED JUN 26 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 24, 1927.

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1927, to 6-24, 1927, that I last saw h-ex alive on 6-24, 1927, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows: Sec. toxemia + cachexia

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary): Cellulitis of neck + face

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death? Follow + Bradow Streets

Did an operation precede death? yes Date of 6-16-27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Wesson, M. D.

, 19 (Address) 1.B Gen Hosp Tel.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem Date of Burial June 27 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Eutaw

very important. See instructions on back of certificates. Full statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23409

CERTIFICATE OF DEATH.

119 E 23409

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 S. 26th St. St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Groll

(a) RESIDENCE NO. 410 S. 26th St. St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE~~ of Pauline H. Groll

6 DATE OF BIRTH (month, day, and year) June 20 - 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	—	5 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer Retired

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Frank A. Gable

(Address) 410 S. 26th St.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per RAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 June 24

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1927, to June 24, 1927, that I last saw him alive on June 23, 1927, and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Syphicarma

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Uremia Acidosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1729 N. Duncan St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Frank A. Glantz, M. D.

June 24, 1927 (Address) 3344 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 27, 1927

20 UNDERTAKER Charles W. Dill. ADDRESS 3109 Fredk. Ave

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23410 — PLACE OF DEATH — 129 — E 23410 — REGISTERED NO. C

CITY OF BALTIMORE (No. 208 Mc Mechen 14-20 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs. Leonora Cooper Somers

(Residence in Baltimore: No. 208 McMechen St. 2 Apt — Duration St.: 84 yrs. 3 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: March (Month) 16th (Day), 1843 (Year)

7 AGE: 84 yrs. 3 mos. 15 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9 BIRTHPLACE (State or country): Mt Pleasant New Jersey

PARENTS

10 NAME OF FATHER: Frank Adams

11 BIRTHPLACE OF FATHER (State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Hannah Santem

13 BIRTHPLACE OF MOTHER (State or country): New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S. Parkhurst

(Address) 1415 Park Ave

15 JUN 26 1927 — C. HAMPSON JONES, M. D. — Per K.K. — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 20 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to June 21 1927, that I saw h.. alive on June 20th, 1927, and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis or Malnutrition

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Alice S. Parkhurst M. D.

June 20, 1927 (Address) 1415 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: 6/28, 1927

20 UNDERTAKER: Henry L. Marsh & Son — ADDRESS: 805 N. Calvert St.

IMPORTANT: CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 23411 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23411

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 221 S Vincent ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael A Murphy

(a) RESIDENCE NO. 221 S Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Murphy

6 DATE OF BIRTH (month, day and year): July 6 1874

7 AGE: Years 52 | Months 11 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer): Foreman D&C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Peter Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine F Murphy

(Address) 221 S Vincent

15 Filed 6 26 1927 C. HAMPSON JAMES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 10 1927 to June 24 1927.

that I last saw living at June 24 1927.

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. O'Donnell M. D.

6/26 1927 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cy

DATE OF BURIAL: 6 [illegible] 1927

UNDERTAKER: George A Farley

ADDRESS: Fulton Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23412

CERTIFICATE OF DEATH.

74-001 E 23412

E 23412
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Hotel Belvidere. St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George M. Martenet.

(a) RESIDENCE NO. 1712 Barclay St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of XXXXXXXXXX: Clara B. Martenet.

6 DATE OF BIRTH (month, day, and year): December 4, 1870

7 AGE: Years 56 Months 6 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Belvidere.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Morris Martenet.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Sarah Hubbard.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore, Md.

14 Informant: James L. Martenet, (son)

(Address): 1712 Barclay St.

15 Filed 19 C. HAMPSON JONES, M.D. Registrar

By

N 26 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D. (Coroner)

6/25 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1712 Barclay St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial June 27 1927

20 UNDERTAKER: Wm. Cook ADDRESS 507 E. Madison

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 23413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 90 E 23413

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore & Calvert Sts. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorin O. Machin.

(a) RESIDENCE NO. Cockeysville, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Widower.

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~XXXXXX~~ ~~XXXXXXXXX~~ Ida M. Machin.

6 DATE OF BIRTH (month, day, and year) October 20, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert Machin.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eugenia Harvey.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Pearl McCaslin. (sisterinlaw)

(Address) Reisterstown, Md.

15 Filed ..... 19 ..... Registrar

UN 26 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

6/25 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cockeysville, Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore June 27 1927 — Date of Burial

20 UNDERTAKER — ADDRESS

Carl von Lehmden

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 23414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117 E 23414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun. Hospital # 30 Ward)

2-FULL NAME Earle Shoeler.

(a) RESIDENCE NO. Cockeysville 2nd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cockeysville, (State or country) Md.

PARENTS

10 NAME OF FATHER John R Shoeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cockeysville, Md

12 MAIDEN NAME OF MOTHER Elizabeth Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cockeysville, Md

14 Informant John R Shoeler (Address) Cockeysville Md.

15 Filed JUN 26 1927 C. HAMPTON JONES, M. D. Registrar Per R.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of Appendix

(duration) 1 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) — yrs. — mos. 1 ds.

June 27 1927 (Signed) J. C. Bialost M. D. (Coroner)

(Address) 143 W Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Cemetary, Balto Co. Date of Burial June 28 1927

20 UNDERTAKER Wm. C. Bowler ADDRESS Sparks, Md.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23415

CERTIFICATE OF DEATH.

74-801 E 23415

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Orleans ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patient Nashields

(a) RESIDENCE NO. 1419 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Indefinite yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Mar. 27-1854

7 AGE: Years 73 Months 2 Days 26 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hw

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Mr. Westberry

11 BIRTHPLACE OF FATHER (City or town) (State or country): Eastern Shore

12 MAIDEN NAME OF MOTHER: Mrs Westberry

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Eastern Shore Md

14 Informant (Address): Agnes Evans 1419 Orleans

15 Filed JUN 26 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-20-1927, to 6-23-1927, that I last saw her alive on 6/23-1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Apoplexy, Hemiplegia (Paralytic stroke)

(duration) 3 days

CONTRIBUTORY (Secondary) Hepatitis & Chronic Arteries (duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hw

Did an operation precede death? Hw Date of

Was there an autopsy? Hw

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. E. Blake, M. D.

19 (Address) 1402 Jefferson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery

DATE OF BURIAL: June 27 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 orleans st

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23416

CERTIFICATE OF DEATH.

24 E 23416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 S. Durham ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wilson

(a) RESIDENCE NO. 219 S Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE: Years 79 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Patterson

(Address) 219 S Durham St

15 Filed JUN 26 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927 to June 25, 1927

that I last saw h alive on June 24 1927

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Natural Cerebral

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W Clyde Stevens M. D.

June 27 1927 (Address) 2017 E 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL June 28 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1691 Orleans St

Spec.–7-17-26—A Co.—200 Bks.

Bottomley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23417

CERTIFICATE OF DEATH

× 46

E 23417

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

City of BALTIMORE: (No. 11-24 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Batlomley

(a) RESIDENCE NO. Aberdeen Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 11, 1856

7 AGE: Years 72 Months 1 Days 14

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housf.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England.

PARENTS

10 NAME OF FATHER Geo. Keightley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Hospital Record

(Address)

26 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to June 25, 1927, that I last saw her alive on June 25, 1927, and that death occurred, on the date stated above, at 10 55 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? 6-6-27 Date of yes

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Timonium Md. June 27 1927

UNDERTAKER George L. Schwab ADDRESS 511 Preston

IF DEATH IS from any disease that may be communicable, it is the duty of the attending physician to fill out and sign the certificate of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

9 E 23418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 E 23418 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 14-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Jones

(a) RESIDENCE NO. 537 Wilson St St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-16-26

7 AGE: 0 Years / Months 11 / Days 8 / IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Felix Jones

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Rosie Ellis

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 26 1927 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1927, to June 24, 1927, that I last saw h[illegible] alive on June 24, 1927, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

pertussis

(duration) .....yrs. .....mos. 8 ds.

CONTRIBUTORY (Secondary) pneumonia

(duration) .....yrs. .....mos. 6 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! NO Date of

Was there an autopsy! yes

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 by (Official)

JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Antony Cemetery Date of Burial June 27 1927

20 UNDERTAKER: Robert A. Millikin ADDRESS 1515 Mt. Royal

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 23419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 188-001

E 23419

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St. 4-31 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 48.)

2-FULL NAME Elmer S. Claggett.

(a) RESIDENCE NO. Hobtoille Old St. _____ Ward _____ Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Claggett.

6 DATE OF BIRTH (month, day, and year): June 10-1901

7 AGE: Years 26 Months ____ Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer): Canton

(c) Name of employer: Rail Road

9 BIRTHPLACE (city or town) ____ (State or country) Md.

PARENTS

10 NAME OF FATHER: Alfred S. Claggett

11 BIRTHPLACE OF FATHER (city or town) ____ (State or country) Md.

12 MAIDEN NAME OF MOTHER: Jesse Daly

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Md.

14 Informant: Mr. Norman J. Claggett (Address) 776 Gantly St.

15 Filed NOV 26 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

* R. R. Accident

Fracture of Skull

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. C. Yates M. D. (Coroner)

June 30 19 27 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md. Date of Burial June 27 1927

20 UNDERTAKER: George L. Schwab ADDRESS 1501 Fulton Ave.

very important. See instructions on back of certificate.

Exact statement of OCCUPATION is

Spec.—12-9 25—A Co.—200 Pks.

E 23420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

E 23420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 27-42 Ward)

2-FULL NAME Harry C. McAvoy

(a) RESIDENCE NO. 31 Evergreen Ave, Hamilton St. Ward

(Usual place of abode) Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine E. McAvoy

6 DATE OF BIRTH (month, day, and year): July 24—1888

7 AGE: Years 38 Months 10 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Purchasing Agent

(b) General nature of industry, business, or establishment in which employed (or employer): Office Manager

(c) Name of employer: State Road Commission

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER: Chas. McAvoy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER: Mary Thornton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

14 Informant: Catherine E. McAvoy

(Address) 31 Evergreen ave Hamilton

15 Filed NOV 26 1927 19 17 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 24th, 1927, to June 23rd, 1927, that I last saw him alive on June 23, 1927, and that death occurred, on the date stated above, at 9.05 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Pneumonia, edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. G. Lucas, M. D.

6-23, 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery Date of Burial 6/27 1927

20 UNDERTAKER: Chas F. Grauel & Son ADDRESS 118 W Mt Royal ave

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22491

E 23421

CERTIFICATE OF DEATH.

48 E 23421

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 W. Fayette St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Watts

(a) RESIDENCE NO. 1035 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced (or) WIFE of: Geo. H. Watts

6 DATE OF BIRTH (month, day, and year): April 4, 1839

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	88	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Kent County

(State or country): Maryland

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mrs. J. B. Toulson

(Address) 1035 W. Fayette St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to June 25, 1927, that I last saw h[illegible] alive on June 18, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis, Myocarditis, epithelioma of the face (duration) ~~yrs~~ over 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Henry C. Cole M. D.

6-25, 1927 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Chapel - Kent Co. Md. Date of Burial 6/29/27

20 UNDERTAKER: Edward Toulson ADDRESS 900 Wood Avenue

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23422

CERTIFICATE OF DEATH.

74-08 E 23422

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Calvin

(a) RESIDENCE NO. 614 Forrest St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1856

7 AGE: Years 70 Months 11 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER James Caldwell

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary C. Mansfield

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant: Balto City Hospital Records

(Address)

15 Filed JUN 27 1927, 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY Arterio Sclerosis

(Secondary)

(duration) yrs. mos. 2 ds.

June 27 1927 Signed G C Yates M. D. (Coroner)

, 19 (Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 27 1927

20 UNDERTAKER H. E. Lord ADDRESS 507 E Lodge

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23423

CERTIFICATE OF DEATH.

169 E 23423

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Boat Lake Pat Pk. St. 1-V Ward)

2-FULL NAME Stefan Marcinkowski

(a) RESIDENCE NO. 2741 East 10th St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1863.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 58

(b) General nature of industry, business, or establishment in which employed (or employer) Stant Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Marion Marcinkowski.

(Address) 2741 East ave.

15 Filed _____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Drowning

(duration) 1/2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Injured

(duration) 1 yrs. ___ mos. ___ ds.

June 27 1927 (Signed) Geo Claude Pollard M. D. (Coroner)

(Address) 436 N Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial June 28 1927

20 UNDERTAKER George A. Weber ADDRESS 2205 Eastern

If DEATH is from any form of violence, state whether accidental, suicidal or homicidal, and the means of injury; and in such cases the Coroner must hold an inquest before a certificate is issued. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 27 1927 C. HAMILTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23424 — 168 — E 23424

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 S. Bouldin St., 26-2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Grocki

(a) RESIDENCE NO. 602 S. Bouldin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mary Grocki

6 DATE OF BIRTH (month, day, and year): Dec. 27-1880

7 AGE: 46 Years 5 Months 26 Days — IF LESS than 1 day.....hrs. or.....min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Poland.

(State or country)

PARENTS

10 NAME OF FATHER: Max Grocki.

11 BIRTHPLACE OF FATHER (city or town): Poland.

(State or country)

12 MAIDEN NAME OF MOTHER: unknown.

13 BIRTHPLACE OF MOTHER (city or town): Poland.

(State or country)

14 Informant: Mrs. Mary Grocka.

(Address): 602 S. Baldwin St.

15 Filed JUN 27 1927, 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Strangulation

(Duration) yrs. mon. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mon. 1 ds.

(Signed) G. C. Hahn M. D.

(Coroner)

19 (Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mon.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft Stanislaus Con. — Date of Burial: June 28 '27

20 UNDERTAKER: Siegel & Weber — ADDRESS: 2205 Bank st

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23425

CERTIFICATE OF DEATH.

185 E 23425

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. New Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl H. Barnard Gibbs

(a) RESIDENCE NO. 3425 Holmes St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4th 1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer School #61

9 BIRTHPLACE (city or town)

(State or country) Williamsport Pa

PARENTS

10 NAME OF FATHER Dr Charles Gibbes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Texas

12 MAIDEN NAME OF MOTHER Henrietta Elliott Gibbes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Mrs Henrietta E. Gibbes

(Address) 3425 Holmes ave

15 Filed ....., 19 C. HAMILTON JONES, M. D.

Per K.J.C. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

Fracture of Skull.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ..... yrs. ..... mos. 1 ds.

June 25, 19 27 (Signed) G. H. Bates M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Wood Cemetery N.Y. Date of Burial 6/28 1927

20 UNDERTAKER Chas. Weber & Son ADDRESS 2503 Edmondson Ave

NOT VALID

If death is to be cremated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 23426 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23426

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Ceil Av ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katie Nash

(a) RESIDENCE NO. 2006 Ceil Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? +0 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nash

6 DATE OF BIRTH (month, day, and year) 9/15/1867.

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
59	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Henley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Rosa Wheaton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rose Murphy (Address) 2006 Ceil Av

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

N-2-1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb-21- 1927 to June 23 1927.

that I last saw h[illegible] alive on June 23 1927.

and that death occurred, on the date stated above, at 7-30P m.

The CAUSE OF DEATH* was as follows:

Uremia -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) E Gill Hall M. D.

6/26 1927 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green Balt Co. DATE OF BURIAL 6/30/27

20 UNDERTAKER George J [illegible] ADDRESS 735 Hanover E

CAUTION is very important. See instructions on back of certificates. Exact statement of OCCUPATION is necessary in all cases, so that it may be properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 ✓ 1927
43
E 23427 ✓ 884

E 23427

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 46-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lee

(a) RESIDENCE NO. 1941 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Lee

6 DATE OF BIRTH (month, day, and year): Mar 1884

7 AGE — Years: 43 Months: 3 Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of indostry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Edw Parker

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Fred Co Md

12 MAIDEN NAME OF MOTHER: Eliza Wade

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Howard Co

14 Informant: 1941 N Stricker

(Address): Eliza Jones

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

Per .....

JUN 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1927

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to June 24, 1927, that I last saw her alive on June 24, 1927, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Interstitial)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jonathan Taylor M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lucas Date of Burial June 27 1927

20 UNDERTAKER: Emma E. Dryden ADDRESS 1136 Mon

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23428

CERTIFICATE OF DEATH.

187-007

REGISTERED NO. E 23428

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Casey

(a) RESIDENCE NO. 533 N Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola Casey

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 40; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Prince Edward Co. Va.

(State or country)

PARENTS

10 NAME OF FATHER: Benjamin Casey

11 BIRTHPLACE OF FATHER (city or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Bell - Watson

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Viola Casey

(Address) 533 Bond St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 23 1927

17 I HEREBY CERTIFY, That I held Inquiry of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Coronary Thrombosis

Syphilis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Dated June 23 1927 M. D.

(Coroner)

(Address) 413 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery Date of Burial 1927

20 UNDERTAKER: Samuel Amuslay ADDRESS 1711 Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 27 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 23429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH ~~E 23429~~

CITY OF BALTIMORE: (No.) 3830 Sequoia Ave ST. 15th WARD)

2-FULL NAME John Emory Auld Sr.

(a) RESIDENCE No. 3830 Sequoia Ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Auld

6 DATE OF BIRTH (month, day, and year) Nov 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Bridge & Steel

(c) Name of employer 66

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Auld

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant John E Auld Jr
(Address) 3830 Sequoia Ave

15 Filed JUN 7 1927 HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to June 25, 1927, that I last saw h in alive on June 23, 1927, and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH* was as follows:

Malignant neoplasm of Lt Kidney

(duration) yrs. 3 mos ? ds.

CONTRIBUTORY (Secondary) Cerebral metastasis from above (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Manuel D Fisher, M. D.

June 25, 1927 (Address) 1211 Eutaw Place, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL June 27 1927

20 UNDERTAKER John H. Kenny — ADDRESS 712 Light St

FROM is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—5500 Blks.

E 23430 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 23430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Cookie, St. 24-35 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Smith, or Michael B Savage

(a) RESIDENCE NO. 1208 Cookie St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs — mos — ds. How long in U. S. if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Schultz

6 DATE OF BIRTH (month, day, and year) Aug 23 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49	50	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Shipyard~~

(c) Name of employer Bath Steam Ships Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs John Siegel (Address) 1308 Cookie St

15 Filed JUN 27 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/23 1927, to 6/25, 1927, that I last saw h— alive on 6/23 1927 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis + Hypertension

(duration) Unknown mos ds

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) Dan Drumheller, M. D.

6/25 1927 (Address) 1??? ??????

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus

DATE OF BURIAL June 28, 1927

20 UNDERTAKER Chas. L. Ehrmann.

ADDRESS E Fort Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23431

CERTIFICATE OF DEATH.

49E 23431

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1745 E. Eager ST., 7-13 WARD)

2-FULL NAME George L. Campbell

(a) RESIDENCE No. 1745 E. Eager ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma R. Campbell

6 DATE OF BIRTH (month, day, and year) May 18-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. L. Campbell, Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Henrietta Schaar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Emma R. Campbell
(Address) 1745 E. Eager St.

15 Filed JUN 27 1927, 19 H. HAMPSON HOOPES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to June 25, 1927, that I last saw her alive on June 25, 1927 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder
Pelvic Pyonephrosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Anuria

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin M. Joplin, M. D.

, 19 (Address) 2028 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL June 28 1927

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St

TION is very important See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23432

CERTIFICATE OF DEATH

E 23432

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 22 N. Carey St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elma V. Stone

(a) RESIDENCE NO. 22 N. Carey St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Henry Stone

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER James H. Galo

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Mamie Kaiser.

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Kent Co. Md.

14 Informant J. Page Galo.
(Address) Rock Hall Kent Co. Md.

15 Filed JUN 27 1927 19 C. HAMPSON JONES, M. D. Registrar
Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to June 25, 1927.

that I last saw her alive on June 25, 1927.

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) — yrs. — mos. 2 da.

CONTRIBUTORY (Secondary) Chronic valvular heart over

(duration) yrs. mos. 2 da.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical tests

(Signed) Henry C. Blake, M. D.

6.26.1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Paul Crem. Kent Co. Md.	June 27 1927

20 UNDERTAKER Wilbur W. Shriver ADDRESS 1018 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23433

CERTIFICATE OF DEATH.

90 E 23433

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at the Mercy Hospital. St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry R. Harris.

(a) RESIDENCE NO. 1706 E. Fayette St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of (or WIFE of) XXXXXXXXXXXX Mary Harris.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Casualty Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Luke Fisher. (soninlaw)

(Address) 1018 E. 36th St.

15 Filed JUN 27 1927 H. AMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBITORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. W. Leinbach (Coroner)

6/25, 1927 (Address) 1017 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? Hearst Tower Building. Balto. & North

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial June 28 1927

20 UNDERTAKER William Cox ADDRESS 526 E. North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+100-001

E 23434

REGISTERED NO. E 23434

E 23434
1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Street Ward 9)

2-FULL NAME Henry Prell

(a) RESIDENCE NO. Shore Rd. 7. Middle River; Baltimore County
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Mary Prell

6 DATE OF BIRTH (month, day, and year): Nov 23 89

7 AGE: Years 37 | Months 9 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Goodman Cafe

9 BIRTHPLACE (city or town): Balto
(State or country): Md.

PARENTS

10 NAME OF FATHER: George S. Prell

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Hoffman

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Mrs Mary Prell Armentrout
(Address) 200 S. Fifth St

15 Filed ..... 19 .....
Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 21 1927, to June 25, 1927, that I last saw him alive on June 25, 1927, and that death occurred, on the date stated above, at 3:00 a m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Vernon N. Norwood, M. D.

June 25 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loch Raven — Date of Burial: June 28 1927

20 UNDERTAKER: Pohly & Henry — ADDRESS 2116 Eutaw St

JUN 27 1927 C. HAMILTON JONES, M. D.

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23435

CERTIFICATE OF DEATH.

100-001 E 23435

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 426 E. 23rd St. St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard A. Coureton.(C)

(a) RESIDENCE NO. 7 W. Lafayette Ave. St. Ward 8th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) October 1, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Thaddeus Coureton.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Wilma Bland.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Wilma Coureton.(C) mother.

(Address) 7 W. Lafayette Ave.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
Eclampsia.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

.....M. D.
(Coroner)

6/27, 19 27 (Address) 1017 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

7 W. Lafayette Ave.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va Date of Burial June 28 192 7

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 725 Ashland Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Goings

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 23436 REGISTERED NO.

E 28436 CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 916 - Hillman St. 10-14 Ward)

2-FULL NAME Lena Goings

(a) RESIDENCE NO. 916 Hillman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Thomas Bolling

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Isabella

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Edna Goings

(Address) 916 Hillman St.

15 Filed 19

By H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 27, to June 23, 19 27,

that I last saw h.. alive on June 22, 19 27,

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home 2 death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) L. A. Johns, M. D.

, 19 (Address) 2329 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Laurel Cemetery June 27

20 UNDERTAKER ADDRESS

Mrs R. A. Elliott 1225 Ashland av

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-801 ✓ E 23437

E 23437

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Pearlman

(a) RESIDENCE NO. 2246 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 26, 1927.

7 AGE: Years | Months | Days | IF LESS than 1 day 3 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Louis Pearlman

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Rotenberg

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant Hosp. Record

(Address)

15 Filed 19

Per Registrar

E. HAMPSON JONES, M. D.

NOV 27 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-26-27

17

I HEREBY CERTIFY, That I attended deceased from 6-26 19 27 to 6-26 19 27, that I last saw h alive on 6-26 19 27, and that death occurred, on the date stated above, at 2.08 p. m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Weinstein, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Hebrew Mt Carmel Date of Burial 6-27-1927

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 23438

CERTIFICATE OF DEATH.

90 E 23438

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2206 Hoff St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara S. Hartman

(a) RESIDENCE NO. 2206 Hoff St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late John Hartman

6 DATE OF BIRTH (month, day, and year): Dec 3 1856

7 AGE: Years 70 Months 6 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewoman.

(b) General nature of industry, business, or establishment in which employed (or employer): at John Hopkins

(c) Name of employer: Hospital

9 BIRTHPLACE (city or town)

(State or country): Germany.

PARENTS

10 NAME OF FATHER: Dont know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant: John L. Bupmer

(Address): 3403 Muler st.

15 Filed ..... 19 C. HAMPSON JONES, M. D.

Registrar

JUN 27 1927 per K K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Edema

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

Edema

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. C. Hawkes M. D.

(Coroner)

June 27, 19 (Address) 4361 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: June 27 1927

20 UNDERTAKER: Lilly Zeiler ADDRESS: 403 S. Wolfe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 23439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182

E 23439

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Harbor Hosp) (St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Labuda.

(a) RESIDENCE NO. 3031 Elliott St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 14/16

7 AGE: Years 11 Months 5 Days 8 IF LESS than 1 day.....hrs. or.....min. 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Paul Labuda

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Susanna Furisi

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Bohemia

14 Informant Susan Labuda

(Address) 3031 Elliott St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: (Over)

Drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. ..... ds.

June 25 1927 (Signed) C. Pardue M. D. (Coroner)

19 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial June 25 1927

20 UNDERTAKER: Paul Brackton ADDRESS 1966 Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Hrebik

HEALTH DEPARTMENT—CITY OF BALTIMORE

903489

E 23440

CERTIFICATE OF DEATH.

16 E 23440

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Hrebik

(a) RESIDENCE NO. 948 N-Duncan St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 7-25-82

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia

(State or country)

PARENTS

10 NAME OF FATHER James Hrebik

11 BIRTHPLACE OF FATHER (city or town) Bohemia

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant Friends-

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

JUN 27 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1927, to June 25, 1927, that I last saw him alive on June 25, 1927, and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH* was as follows:

Tabo-paresis.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Spinal fluid.

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Date of Burial June 28 1927

20 UNDERTAKER Frank E. Cockson ADDRESS 1906 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 23441

E 23441 REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital

City of BALTIMORE: (No. Caroline & Oliver St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle E. Yokel

(a) RESIDENCE NO. 2707 E. Chase St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Garment Worker~~

6 DATE OF BIRTH (month, day, and year): October 1910

7 AGE: Years 16 Months 8 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Garment Worker.

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Yokel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Etoff.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Yokel

(Address) 2707 E. Chase St.

15 Filed ..., 19... C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24. 27 19

17 I HEREBY CERTIFY, That I attended deceased from June 9, 19 27, to June 26, 19 27

that I last saw her alive on June 26, 19 27

and that death occurred, on the date stated above, at 5:17 p. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. 2 mos. da.

18 Where was disease contracted at home.

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) H. H. McCausland M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sykesville Md. Date of Burial: June 28 1927

20 UNDERTAKER: Weer & Son Inc. ADDRESS: Sykesville Md

JUN 27 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23442

CERTIFICATE OF DEATH.

45 E 23442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 So Stricker St. ST. 14-28 WARD)

2-FULL NAME James M/ Chesney

(a) RESIDENCE NO. 426 So. Stricker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Barbara Chesney

6 DATE OF BIRTH (month, day, and year) Dec. 3rd. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 014

(b) General nature of industry, business, or establishment in which employed (or employer) Cabinet Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Chesney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alnora Griggs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Barbara Chesney (Address) 426 So. Stricker St.

15 Filed JUN 27 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-12- , 1926 , to 6/25 , 1927 that I last saw h alive on 6/25/ , 1927 and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum & Colon

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stuyvesant Dean, M. D.

, 19 (Address) 1420 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL 6/28/27

20 UNDERTAKER Harry A Witzke ADDRESS 531 West Lombard St

IMPORTANT. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 23443

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 101 Elm Curtis Bay 25-7721-001 REGISTERED NO. C

CITY OF BALTIMORE: (No. 101 St. Elm WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred N. Budalazy

(Residence in Baltimore: No. 101 Elm St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 19 (Day), 1925 (Year)

7-AGE, 2 yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Andy Budalazy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bertha Lubas

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andy Budalazy

(Address) 101 Elm St

15- Filed JUN 27 1927, 191 C. HAMPSON JONES, M. D. Per Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22 1927, to June 26 1927, that I saw h alive on June 25 1927, and that death occurred, on the date stated above, at 6-25 a m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. H. Booth M. D.

, 191... (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross C.C. Co. DATE OF BURIAL, June 28 1927

20-UNDERTAKER Margaret A. Flynn ADDRESS 1417 Light St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23444

CERTIFICATE OF DEATH.

188-003

E 23444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St., 5th (Ward)

2-FULL NAME James F. Lewis

(a) RESIDENCE No. 1404 E Lexington St. Ward

(Usual place of above)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Lewis

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 48 Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant Rosa Lewis

(Address) 1404 E Lexington st

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cut Artery Crushed Abdomen

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

June 25 1927 Signed G C Yates M. D. (Coroner)

19 (Address) 1431 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbury Date of Burial: June 28 1927

20 UNDERTAKER: John W Henderson E Monument ADDRESS 1502

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23445

CERTIFICATE OF DEATH.

46 E 23445

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Weil

(a) RESIDENCE NO. 1700 Eutaw place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leon Weil

6 DATE OF BIRTH (month, day, and year): Dec. 29, 1858

7 AGE — Years: 68 Months: 5 Days: 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Emanuel Fleischer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Strauss

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Rev. Seymour Weil

(Address) 1700 Eutaw Place

15 Filed JUN 27 1927 C. HAMPSON JONES, M. D. Registrar

Per A. M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6/25/27 - 4 A.M.

17 I HEREBY CERTIFY, That I attended deceased from 5/31, 1927, to 6/25, 1927, that I last saw h[illegible] alive on 6/25, 1927, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Paralysis of Intestines

[illegible] of Heart (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 6/2/27.

Was there an autopsy? no Clinical, Lab. findings. Op.

What test confirmed diagnosis?

(Signed) John A. Askin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. Date of Burial 6/27/1927

20 UNDERTAKER: Harry Sondheim ADDRESS 118 20th. Ave. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

E 23446
1 PLACE OF DEATH

E 23446
REGISTERED NO.

City of BALTIMORE: (No. 244 N. Bruce St. 14-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Culvain Anthony

(a) RESIDENCE NO. 244 N. Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 11, 1927

7 AGE: Years 15 Months Days 14 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. Anthony

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Columbia S. C.

12 MAIDEN NAME OF MOTHER Mary E. Connell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Elizabeth City N C

14 Informant Chas Anthony
(Address) 244 N Bruce St

15 Filed JUN 27 1927, 19 C. HAMPSON JONES, M. D.
Registrar
Per R. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
6/25/27

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 27, to June 25, 19 27, that I last saw h[illegible] alive on June 24, 19 27, and that death occurred, on the date stated above, at 9 4 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Lou complicated
(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) W. J. Horton, M. D.
, 19 (Address) 1814 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — Date of Burial 6-27 1927

20 UNDERTAKER: Joseph A. Lively — ADDRESS 410 Mount St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

E 23447 — REGISTERED NO. E 23447

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Ott

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not known

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): ?

(State or country): Germany

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country)

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country)

14 Informant: Little Sisters of the Poor

(Address): Preston & Valley St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

NOV 27 1927 Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from No record 19..... to 19.....,

that I last saw her alive on June 19, 1927,

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

June 25, 1927 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial 6/28 1927

20 UNDERTAKER: C. T. Hartle — ADDRESS 1156 E. Preston

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stec—12-23-21—E.B.R.S.—400 Bks.

E 23448

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 E 23448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 746 N Lexington St., 4-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Fraske

(a) Residence No. 746 N Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Fraske

6-DATE OF BIRTH (month, day and year) Feb-6 1839

7-AGE. 88 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER. Goblet Fraske

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

11- (Informant) Record at Augsburg Home

(Address) 746 N Lexington St

15- Filed JUN 27 1927 192 Per RAC C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-24-27

I HEREBY CERTIFY, That I attended deceased from Jan 5th 1927 to June 24 1927

that I last saw h[im] alive on June 18 1927

and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

General Debility.

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) old age.

(Duration) 3 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo Hemmeter M. D.

June 25 1927 (Address) 302 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park.	6-27, 1927

20-UNDERTAKER. Wm Chas A Rhode ADDRESS 2327 Edmondson Av

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23449

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 23449

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. ____ St., 9-17 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gerst

(a) RESIDENCE NO. Fullerton Md. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 4 ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Gerst

6 DATE OF BIRTH (month, day, and year): July 15 1872

7 AGE: Years 54 Months 11 Days 11 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General natore of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER: Joseph Snyder

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Mary Coster

13 BIRTHPLACE OF MOTHER (City or town): ____

(State or country) Holland

14 Informant: Jacob Gerst

(Address) Fullerton Md.

15 Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

Per ____

N 2 7 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/ 1927

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1927 to June 26, 1927

that I last saw h[illegible] alive on June 26, 1927

and that death occurred, on the date stated above, at 1 [illegible] m.

The CAUSE OF DEATH* was as follows:

(a) Dr. Dorie Gaither.

(b) Myocarditis

(duration) 5 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(doration) ____ yrs. ____ mos. 2 hrs. ____ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Edmund P. Thomas M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cemetery — Date of Burial: June 28 1927

20 UNDERTAKER: Frederick Deacon Sons — ADDRESS: Fullerton Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23450

3 / E 23450

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Olive St. Ward 23-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Blottenberger

(a) RESIDENCE NO. 1709 Olive St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 8 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Oct, 23, 1903.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23,	8,	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster.

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric

(c) Name of employer CO.

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Blottenberger.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Huber.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Katherine blottenberger.

(Address) ~~1709 Olive Street.~~

15 Filed 2 7 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1927. 19 7 P.M.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to June 25, 1927, that I last saw h alive on June 25, 1927, and that death occurred, on the date stated above, at 7-A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Septicaemia

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] Camp M.D.

June 27, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial June 29, 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23451

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 23451

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto. City Hosp. St., (W.) 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kleby

(a) RESIDENCE NO. 3134 McElderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Klein

6 DATE OF BIRTH (month, day, and year): March 18 1885

7 AGE: Years 42 Months 3 Days 7. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jos. Klein

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Anna Sandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Record

(Address)

15 Filed 6 27 1927 C. HAMPSON JONES, M. D. Registrar

Par RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/25 1927.

17 I HEREBY CERTIFY, That I attended deceased from 4/9 1927 to 6/25 1927.

that I last saw him alive on 6/25 1927.

and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculous enteritis & Peritonitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. McCaffrey M. D.

6/26. 1927 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial: June 28 1927

20 UNDERTAKER: H. Sander Sons ADDRESS: 1710 Eutaw St

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tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATI... is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23452

E 23452

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 621 (St.) Eutaw (Ward) 5-8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lucas

(a) RESIDENCE NO. 621 (Usual place of abode) ST. Eutaw WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	col.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25. 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Hugh Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cooks Mound N.C.

12 MAIDEN NAME OF MOTHER Lillie Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lawrence S.C.

14 Informant (Address)

15 Filed 2 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to June 25, 1927, that I last saw h— alive on June 25, 1927 and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sup. Exam

(Signed) W. L. Berry, M. D.

, 19 (Address) 1510 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23453

CERTIFICATE OF DEATH.

11-08 E 23453

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5902 York Road ST. 27-48 WARD)

2-FULL NAME William J. Scarborough

(a) RESIDENCE NO. 5902 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Hudson

6 DATE OF BIRTH (month, day, and year) April 13, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	93	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Scarborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Mary H. Scarborough

(Address) 5902 York Road, Govans

15 Filed JUN 27 1927 19 C. HAMPSON JONES, M. D.

Per RLW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to June 27, 1927, that I last saw him alive on June 27, 1927, and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

Bronchial Pneumonia

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Glen S. Bishop, M. D.

6/27 1927 (Address) 910 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Snow Hill, Maryland

DATE OF BURIAL 6/28 19 27

20 UNDERTAKER Henry A. Dears & Son

ADDRESS 805 N. Calvert

Via Penn. Railroad Escort - Miss Mary H. Scarborough

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23454 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23454

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3642 Beech Ave. (St.) 13 52 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Harper

(a) RESIDENCE No. 3642 Beech Ave. ST., 13 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Harper

6 DATE OF BIRTH (month, day, and year) Nov. 3-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Wm. H. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Betty Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clinton A. Harper

(Address) 3642 Beech Ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to June 25, 1927.

that I last saw h e alive on June 24, 19...

and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Chr. Int. Nephritis, Chr Myocarditis.

(duration) 2+ yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemmhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. N. Bishop, M. D.

(Address) 501 Sheridan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lion-Freelands (Baltimore) DATE OF BURIAL June 28 1927

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 7 1927

Cor.—12-9-25—A Co.—200 Bks.

E 23455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001

E 23455

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St., 1927 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Miles

(a) RESIDENCE NO. 222 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Miles

6 DATE OF BIRTH (month, day, and year) about 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) Jan 25, 27

(State or country) N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Alabama

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Beatrice Miles

(Address) 222 N. Monroe

15 Filed ..... 19 G. HAMPSON JONES, M. D.

JUN 28 1927 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple fracture of ribs and ruptured [illegible] as a result of accident (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Locomotive & freight car (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessey M. D. (Coroner)

June 28, 27 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial June 28 19 27

20 UNDERTAKER Eugene Waters ADDRESS 423 n Fremont ave

Do not sound be cheaply supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23456

CERTIFICATE OF DEATH.

X 29

REGISTERED NO. E 23456

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas M. Hicks

(a) RESIDENCE NO. Dorsey Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 1909

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Charles Hicks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Edler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs Charles Edler

(Address) Dorsey Md.

15 Filed JUN 28 1927 19 C. VAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc Fracture of Femur Tetanus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) C Lawson

(duration) yrs. mos. ds.

June 27 1927 (Signed) C. E. Blake M. D. (Coroner)

, 19 (Address) 143 E Pray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem Date of Burial June 28 27

20 UNDERTAKER Daniel Easton ADDRESS 96 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 39 61
E 23457

CERTIFICATE OF DEATH.

E 23457

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 37-55 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Waters

(a) RESIDENCE NO. 5337 Sherman Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 25-1925

7 AGE — Years: 2 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country) Baltimore City

PARENTS

10 NAME OF FATHER R H Waters

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Grace Harrison

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 28 1927, 19 H. M. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1927

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to June 25, 1927, that I last saw her alive on June 25, 1927, and that death occurred, on the date stated above, at 6:50 m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tbc)

(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal puncture + Tbc

(Signed) Nathan W E Hanblen, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem Date of Burial June 28/27

20 UNDERTAKER: Daniel Farley ADDRESS 916 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23 158

CERTIFICATE OF DEATH.

168 E 23458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1206 N. Curley St., 8-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Delduca

(a) RESIDENCE NO. 1206 N. Curly St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dominic Delduca

6 DATE OF BIRTH (month, day, and year) June 17, 1875

7 AGE Years	Months	Days 9	IF LESS than 1 day.....hrs. or.....min.
52	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Camel Baptist

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER ----Sbentora

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Dominic Delduca

(Address) 1206 N. Curly St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

JUN 28 1927 By K/K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1927 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation- hung herself to bed post with rope. Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Wales M. D.

(Coroner)

6/27 19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Redeemer Cem. — Date of Burial 6/29/27

20 UNDERTAKER Philip Sterry ADDRESS 2016 Orleans St.

Full name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23459

CERTIFICATE OF DEATH

129 E 23459

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. 2743 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Anstett

(a) RESIDENCE NO. 15 Bellwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Anstett

6 DATE OF BIRTH (month, day, and year) July 25 1852

7 AGE 74 Years 11 Months 29 Days 1 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prussia (State or country)

PARENTS

10 NAME OF FATHER Jacob Anstett

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Mrs Sallie Anstett

(Address) 15 Bellwood Ave Baltimore

15 Filed JUN 29 1927, 19 C. HAMILTON JONES M.C. Registrar R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 21, 19 21, to June 26, 19 27,

that I last saw h alive on June 26, 19 27,

and that death occurred, on the date stated above, at 2:30 pm m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis

(b) Due to Arteriosclerosis

(c)

(d)

3 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes 6/26/27

What test confirmed diagnosis? Clin

(Signed) Clement R. Manning, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lot Dawn

Date of Burial 6 30 1927

20 UNDERTAKER Philip Henry

ADDRESS 2210 Eutaw St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23460

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 1001 E 23460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St., 9-46 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Humphreys

(a) Residence No. 2539 Asquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 23 '27

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 2 hrs. or 4 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter Humphreys

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Missouri

12-MAIDEN NAME OF MOTHER, Elizabeth Zimmerman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Walter Humphreys

(Address) 2539 Asquith St.

15- Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar.

JUN 28 1927 Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 23 '27

17- I HEREBY CERTIFY, That I attended deceased from June 23 19 27 to June 23 19 27

that I last saw him alive on June 23 19 27

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Margaret B. Ballard, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, University Hosp DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23461

CERTIFICATE OF DEATH.

1850

E 23461

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St., 35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam Barct

(a) RESIDENCE NO. 931 E. Baltimore St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Isidore Barct

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Footem

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Isidore Barct (Father)

(Address) 931 E. Baltimore St.,

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JUN 28 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidently fell from 2nd story porch & fractured skull.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. E. Kelly M. D.

(Coroner)

6/28/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Hebrew Mt Carmel Date of Burial 6-28 1927

20 UNDERTAKER Jack Feura ADDRESS 1439 E. Balto. St.,

dis should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE properly classified. Exact statement of OCCUPATION is desirable.

Spec. -7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23462 — 1-PLACE OF DEATH

23-31 124

REGISTERED NO. E 23462

City of BALTIMORE: (No. 108 W.Clement St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Forrest Thornton

(a) RESIDENCE NO. 108 W.Clement St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Thornton

6 DATE OF BIRTH (month, day, and year): July 22 1872

7 AGE — Years: 54 Months: 11 Days: 3 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER: Wm.H.Thornton

11 BIRTHPLACE OF FATHER (City or town): Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER: Hester Bamber

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Md.

14 Informant: Anna Thornton (Wife)
(Address) 108 W.Clement St.

15 Filed JUN 28 1927, 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to June 25, 1927, that I last saw him alive on June 25, 1927, and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows: Abscess between liver & stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Ham, M. D.

, 19 (Address) 1215 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: June 28 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 E 23463

23463

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 N. Wolfe St. 8-13 Ward)

2-FULL NAME Mary L. Harris

(a) RESIDENCE NO. 1113 N. Wolfe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "

(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "

(State or country)

14 Informant Ella Johnson

(Address) 1113 N. Wolfe St.

15 Filed JUN 28 1927 C. HARRISON Jones M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Chr Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Weiss, M. D. (Coroner)

6/28/27 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial June 28 1927

20 UNDERTAKER Lattie Gross ADDRESS 140 S. Gilmor St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23464

E 23464

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1139 W. Lombard St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Schlinkman

(a) RESIDENCE NO. 1139 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Sarah R. Schlinkman

6 DATE OF BIRTH (month, day, and year): May 17, 1844

7 AGE — Years: 83 — Months: 1 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: wheelwright, retired

(b) General nature of industry, business, or establishment in which employed (or employer): retired

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Herman Schlinkman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Knott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): not known

14 Informant: Mrs. Vernon Brown

(Address) 1139 W. Lombard St.

15 Filed ..... 19..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to June 26, 1927, that I last saw h.. alive on June 26, 1927, and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary): Senile arteric sclerosis about 5 years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical test.

(Signed) Wilson C. Otto M. D.

6-27, 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: June 29 1927

20 UNDERTAKER: H. Mayfield — ADDRESS: 1200 W. Lombard St

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23465

CERTIFICATE OF DEATH.

129 E 23465

1-PLACE OF DEATH Dr. White's Hospital

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1029 Madison Avenue ST. 14-20 WARD)

2-FULL NAME Frances Wright

(a) RESIDENCE No. 2038 McCulloh St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Wright

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE — Years: 70 — Months: — Days: — If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 0 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cecelia Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: George Cook

(Address): 2038 McCulloh

15 Filed ....., 19 ..... Registrar C. HAMILTON JONES, M.D.

JUN 28 1927

Asst

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to June 26, 1927.

that I last saw her alive on June 26, 1927

and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion

DATE OF BURIAL: 6/28/1927

20 UNDERTAKER: Mrs. Geo. C. Holland

ADDRESS: 160 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 23466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 Montebello Terr. ST. 1744 WARD)

2-FULL NAME Alexander M Lerch

(a) RESIDENCE NO. 121 Montebello Terrace ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary J. Lerch

6 DATE OF BIRTH (month, day, and year) Oct 18th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigar Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) 617

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary J. Lerch

(Address) 121 Montebello Terrace

15 Filed JUN 28 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1927, to June 27, 1927,

that I last saw him alive on June 26, 1927,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy M. D.

6-27, 1927 (Address) 4218 Hayford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 27 1927

20 UNDERTAKER George Schilling & Sons — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 23467

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23467

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 15-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Miles

(a) RESIDENCE NO. 1337 N. Stockton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: Years 57 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed JUN 28 1927 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1927, to June 24, 1927, that I last saw h[illegible] alive on June 24, 1927, and that death occurred, on the date stated above, at 11 15 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy and Cerebral Hemorrhage

..... (duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial failure

..... (duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R Hampson Jones M. D.

June 24 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial 6/28 1927

20 UNDERTAKER: Thomas E. Kelson — ADDRESS 1293 Preston St

(Spaces must be filled in with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23468

CERTIFICATE OF DEATH.

X 185 E 23468

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hosp (St.) 4 (Ward) 30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances J. McManus

(a) RESIDENCE NO. Londonings Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Detroit Mich

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant Hospital Record

(Address)

15 Filed ....., 19.....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall

Fracture of 12th Dorsal Vert.

Comp. Fracture of R Femur

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

Signed ..... M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md. Date of Burial 6-28 1927

20 UNDERTAKER J. C. Cunningham & Son ADDRESS Havre de Grace Md

JUN 28 1927 C. HAMILTON JONES, M. D.

(If the disease causing death was one of a contagious nature, the Health Officer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23469

CERTIFICATE OF DEATH.

E 23469

REGISTERED NO. 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at Franklin Sq Hosp

City of BALTIMORE: (No. 9 N. Carroll Ave Ward)

2-FULL NAME David Landay

(a) RESIDENCE NO. 9 N. Carrollton ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Landay

6 DATE OF BIRTH (month, day, and year): Dec 15 - 1877

7 AGE: Years 49 Months 6 Days 12 If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEDED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Louis Landay

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Levison

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Minnie Landay

(Address) 9 N. Carrollton ave

15 Filed: JUN 28 1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry), thereon and from the evidence obtained by Inquest, find that said deceased came to death as stated (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by hanging Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

June 27 - 27 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See instructions on back of sheet.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern ave Date of Burial 6/28 1927

20 UNDERTAKER: S. Levinson & Bro ADDRESS 1127 E Baltimore St

(1) ESSENTIAL PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23470

CERTIFICATE OF DEATH.

E 23470

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 6-9 Ward)

2-FULL NAME Samuel Newman.

(a) RESIDENCE NO. 1735 Jefferson St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. _____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	85	---		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Isaac Newman.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia.

12 MAIDEN NAME OF MOTHER Minnie Levey.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia.

14 Informant Minnie Newman. (mother)

(Address) 1735 Jefferson St.

15 Filed _____ 19___ Registrar

E. LAMPSON JONES, M. D.

JUN 28 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull
Accidental Death

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) Otto R. Reinhardt (Coroner)

6/27 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Date of Burial 6/28 1927

20 UNDERTAKER Sol Kleinman & Bro. ADDRESS 1127 E Baltimore St

(If the space provided for answering any question is insufficient, use reverse side and refer to the number of the question.)

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23471

CERTIFICATE OF DEATH

E 23471

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 Forrest St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Ella Shaw,

(a) RESIDENCE NO. 1122 Forrest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of William E. Shaw,

6 DATE OF BIRTH (month, day, and year) November 19. 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Wm. A. Linn,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Nannie Morgan,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Co. Md.

14 Informant Wm. E. Shaw

(Address) 1122 Forrest St. W. D.

15 Filed JUN 28 1927 HAMPSON JONES, M. D. Registrar

JUN 28 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th. 1927, 19

17 I HEREBY CERTIFY, That I attended deceased from May 29th. 1927, to June 28th, 1927,

that I last saw h~~e~~r alive on June 27th, 1927,

and that death occurred, on the date stated above, at 12.35 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) with Left Hemiplegia, 3 1/2 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma (5 days duration) with Heart & Kidney (duration) yrs. mos. 5 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Lehmer Brinton, M. D.

, 19 (Address) 1 W. Eutaw St. 45

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piney Creek Carroll Co.

Date of Burial JUN 30 1927 19

20 UNDERTAKER Geo W Little

ADDRESS

~~MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.~~

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23472

CERTIFICATE OF DEATH.

118-001 E 23472

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 20-27 Ward)

2-FULL NAME Anna T. Schickenmier

(a) RESIDENCE NO. 1914 Fremont Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem'l	white	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schickenmier

6 DATE OF BIRTH (month, day, and year) June 17, 1864.

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	63		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Godfrey Buck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna K. Eichar

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Louis Schickenmier

(Address) 1914 Fremont Av

15 Filed JUN 28 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Post-operative (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Towers M. D. (Coroner)

June 27, 1927 (Address) 202 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 24 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

IMPORTANT—WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23473 — 118-09 — E 23473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No.) St. 22-29 Ward)

2-FULL NAME William O - Gundy

(a) RESIDENCE NO. 709 Dover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mary Gundy

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labores

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Ollie Gundy

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va -

12 MAIDEN NAME OF MOTHER Florence Ward

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUN 28 1927 KRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to June 26, 1927, that I last saw h~~im~~ alive on June 26, 19....., and that death occurred, on the date stated above, at 9-45 A m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Generalized Peritonitis

Intestinal Obstruction

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? 709 Dover St. City

Did an operation precede death? yes Date of 6/24/27.

Was there an autopsy? Yes

What test confirmed diagnosis? ~~Warfield~~ Warfield M. Foss

(Signed) J. Warfield M. Foss, M. D.

, 19 (Address) 744

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharps Whf. Va Date of Burial June 28 1927

20 UNDERTAKER: Samuel T. Hemsley ADDRESS 1525 N Bridge St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23474

CERTIFICATE OF DEATH.

X 198 E 23474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hgts 16-22 St. 16 Ward)

2-FULL NAME Joseph M. Smith

(a) RESIDENCE NO. Melvale, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	color	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about Jan. 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Knife)

(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l Contr.

(c) Name of employer Gen'l.

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Geo. E. Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Peters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Jas. E. Smith

(Address) Melvale, Md.

15 Filed ....., 19 C. HAMPSON JONES, M. D.

JUL 26 1927 Per R C Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage due to Multiple Stab Wounds (in Chest.)

(duration) Few minutes

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) Jas. T. Hennessy M. D.
(Coroner)

27 July, 19 27 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Date of Burial 6-28 1927

20 UNDERTAKER Joseph A Lisby ADDRESS 1209 Monument St

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23475

CERTIFICATE OF DEATH

49 E 23475

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1024 Bennett Place St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Hildebrand

(a) RESIDENCE NO. 1024 Bennett Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. If of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Hildebrand

6 DATE OF BIRTH (month, day, and year) Jan 11th. 1843

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	84	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER George Hildebrand

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Helen Hildebrand

(Address) 1024 Bennett Place.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June, 26th. 27

17 I HEREBY CERTIFY, That I attended deceased from June 1. 27, to June 26 27,

that I last saw him alive on June 25 27,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Infant C Blake, M. D.

6/26, 19 27 (Address) 1014 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial June 28 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W Balto St

JUN 28 1927

THIS CERTIFICATE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23476

CERTIFICATE OF DEATH.

74-001

E 23476

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1711 Wilkens Avenue St. 14-28 Ward

2-FULL NAME Williams Volkert

(a) RESIDENCE NO. 1711 Wilkens Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Volkert

6 DATE OF BIRTH (month, day, and year) December 3, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Sewerage Com.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas H. Volkert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ~~Schultheis~~

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Amelia Volkert

(Address) 1711 Wilkens Avenue

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by Inquest

(Inquest, autopsy or inquiry.)

find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

20 Minutes

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

June 27 1927 (Signed) Thos. B. Horton M. D.

(Coroner)

(Address) Cedar & Curtis Avenue

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Baltimore, Md

18 LENGTH OF RESIDENCE (For Stillbirths, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant View Date of Burial June 30" 1927

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 West Baltimore St

C. HAMPSON [illegible] M. D.

Pur

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23477

CERTIFICATE OF DEATH.

E 23477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S Ch St ST.; 26-27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Schultz

(Residence in Baltimore: No. 816 S Ch St St.; yrs., mos. da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 6 (Month) 26 (Day), 1927 (Year)

7-AGE, Yrs. Mos. Da. Twin Babies

If LESS than 1 day, 2 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John H Schultz

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Linnell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. W. Schultz

(Address) 816 S Ch St

15-

Filed ..... 191.....

C. HAMPSON JONES, M. D.

Registrar.

JUN 28 1927 Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 26 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-26 1927 to 6-26 1927 that I saw h[illegible] alive on 6-26 1927 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Premature (Twin Babies)

Placenta Previa

Hemorrhage (Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) J. Wm Pinckney M. D.

6-27 1927 (Address) 100 N Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem

DATE OF BURIAL, June 28, 1927

20-UNDERTAKER Zilly - Zeller

ADDRESS 403 S. Wolfe St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Hornstein 733 Asquith St.

23478 E

CERTIFICATE OF DEATH

44 E 23478

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2304 E. Hoffman St., 8th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter W. Nelson.

(a) RESIDENCE NO. 2304 E. Hoffman St. 7 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie M. Nelson

6 DATE OF BIRTH (month, day, and year) Nov. 16th 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
67	68	7	9	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Foreman of Lasthorsman

(b) General nature of industry, business, or establishment in which employed (or employer) Tarness Whitley Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter W. Nelson

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Austria.

12 MAIDEN NAME OF MOTHER Mary McNeil

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Addie M. Nelson
(Address) 2304 E. Hoffman

15 Filed ... 19 ... C. HAMPSON JONES M. D. Registrar

JUN 28 1927 Per ... A.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1926, to June 24 1927, that I last saw h[im] alive on June 24 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ... yrs. 0 mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No Findings

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Adolph Hornstein, M. D.

6/27 1927 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial June 29 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23479 E 23479

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Bon Secours Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 26-37 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Barbara Katharine Zorn

(a) RESIDENCE NO. 3816 Foster Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, (or) WIFE of the late Lorenz Zorn

6 DATE OF BIRTH (month, day, and year) June 6th 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ..... mnts.
68		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Amling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph T. Zorn
(Address) 3816 Foster Ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 27, 1927.

that I last saw her alive on June 27, 1927,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic hepleritis-Interstitial.
Vesical Calculus
Carcinoma of bladder

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Same Her

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 10 '27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) George O Eaton, M. D.

, 19 (Address) Bon Secours Hosp'l.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL July 1st 1927

20 UNDERTAKER Lilly - Zeiler ADDRESS 1433 E. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should be careful to supply

C. HAMPSON JONES, M. D.

NOV 28 1927

Registrar

Spec.—1-12-23—M&T—500 Blks.

E 23480

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23480

CERTIFICATE OF DEATH

127

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 851 Lemmon ST. 19-26 (WARD)

2-FULL NAME Benjamin Scott

(a) RESIDENCE NO. 851 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR ~~OR RACE~~	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife Living

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	2	11	

April 4th

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: W. B. & A. R. R.

9 BIRTHPLACE (city or town) (State or country): St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER: Benj. F. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Rosa Wasey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Mary's Co.

14 Informant: John F. Butler

(Address): 851 Lemmon st.

15 Filed ..... 19 ..... Registrar.

C. HAMPSON JONES, M. D.

6 28 1927

APH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to June 26, 1927, that I last saw h[illegible] alive on June 26, 1927, and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Posture

(Signed) Dr. [illegible] M. D.

6-26 1927 (Address) 708 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Albion Cemtery

DATE OF BURIAL: 6/29 1927

20 UNDERTAKER: Wells B. Sp[illegible] 990

ADDRESS: 139 W. Hamburg St.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 23481

E 23481

CERTIFICATE OF DEATH

REGISTERED NO. 21502

1-PLACE OF DEATH

City of BALTIMORE: (No. 1447 Washington Blvd Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Smith

(a) RESIDENCE NO 1447 Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob H. Smith

6 DATE OF BIRTH (month, day, and year): Aug 6 1857

7 AGE 69 Years 10 Months 21 Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexander Va

(State or country)

PARENTS

10 NAME OF FATHER McEuen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Edward C. Flee

(Address) 1447 Washington Blvd

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

17 I HEREBY CERTIFY That I attended deceased from March 1927 to June 27 1927, 19 ....., that I last saw her alive on June 27 1927, 19 ....., and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) one year mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) instant yrs. mos. ds.

Where was disease contracted —

If not at place of death

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) Bernard J. Feeney M. D.

6/29, 1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: June 30 1927

20 UNDERTAKER: Jos Joerdens Son ADDRESS 2178 E. P.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

JUN 28 1927

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 23482

HEALTH DEPARTMENT—CITY OF BALTIMORE E 23482

CERTIFICATE OF DEATH

100-0

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1521 Argyle Ave (St.) 14-20 (WARD)

2-FULL NAME Florence Hammond

(a) RESIDENCE NO. 1521 Argyle Ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 8 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 24-1926

7 AGE — Years: — Months: 8 Days: 4

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: James R. Thomas

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mattie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mattie Thomas

(Address): 1521 Argyle ave

15 Filed ..... 19 .....

Registrar

NOV 28 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1927

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1927 to June 28, 1927

that I last saw her alive on June 28, 1927

and that death occurred, on the date stated above, at 11.10 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. J. W. Kennard, M. D.

6-28 1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: June 29th 27

20 UNDERTAKER: Hamm Earbor

ADDRESS: 916 Da ave

C. CAMPBELL LOWE, M.D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23483 | 16 | E 23483

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2023 Ridgewood Ave) Ward 15-20

2-FULL NAME James L. Parsons

(a) RESIDENCE NO. 2023 Ridgewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Jas L. Parsons

6 DATE OF BIRTH (month, day, and year): about 1874

7 AGE: Years: about 53 Months: Days: IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Pvt

(c) Name of employer: self

9 BIRTHPLACE (city or town): [illegible]

(State or country): Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mrs L M Gilliam

(Address) 2023 Ridgewood Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

APR 28 1927 By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by hanging. (Rope)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

19 27 (Address) 2502 Eldendon ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the state ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kent Co Md Date of Burial: June 29 1927

20 UNDERTAKER: Daniel Easton ADDRESS: Dame 9/6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23484

23484

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2106 N Mulberry (St.) (Ward) 20-69

2-FULL NAME Baby Sickle

(a) RESIDENCE NO. 2106 N Mulberry St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28/27

7 AGE Years Months Days If LESS than 1 day, 8 hrs or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert Sickle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lorina Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert Sickle

(Address) 2106 W Mulberry St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/28, 1927, to 6/28, 1927, that I last saw h.. alive on 6/28, 1927 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Atalectasis

(duration) yrs. mos. 4 hrs ds.

CONTRIBUTORY (Secondary) Premature baby

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Emphysema Lungs

(Signed) Chas H Ellis M. D.

6/28 1927 (Address) 2105 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 6/29/27

20 UNDERTAKER Harry H Weitzka — ADDRESS 1531 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23485

CERTIFICATE OF DEATH

159-003 E 23485

1-PLACE OF DEATH St Joseph's Hospital

REGISTERED NO.

City of BALTIMORE: (No. 25-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eileen Hyland.

(a) RESIDENCE NO. Curtis Bay Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/3/07

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	25	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER N. J. Hyland

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Agnes Pressor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mary J. Hyland

(Address) 110 Poplar St.

15 Filed JUN 28 1927 19 C. HAMPSON JONES, M. D. Registrar

Per ACS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 28, 1927,

that I last saw her alive on June 28, 1927,

and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Pyaemia Bifida

Life

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted Hospital

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clarence R. Merson, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral	6/29 1927
20 UNDERTAKER J. J. Staley & Sons	ADDRESS 1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 E 23486

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 S Paca St. Ward 21-29)

2-FULL NAME Jesse Franklin Benson

(a) RESIDENCE NO. 915 S Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 2/1908

7 AGE: Years 18 Months 8 Days 24 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Sexton Bros

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Grant J Benson

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Lillian L Wagner

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Lillian L Benson

(Address) 915 S Paca St

15 Filed JUN 29 1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Indigestion

(duration) yrs. mos. 4 hrs

CONTRIBUTORY (Secondary) C Laughpe

(duration) yrs. mos. ds.

(Signed) C C Yates M. D.

(Coroner)

27/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem Date of Burial: Jun 30 1927

20 UNDERTAKER: William Cook ADDRESS: 502 E Balto

Spec. -7-17-26 —A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23487 — 31 — E 23487

REGISTERED NO. 13-59

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (T.B.) St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lennie Shoemaker

(a) RESIDENCE NO. 1502 Retreat St. 4444 Calden st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Shoemaker

6 DATE OF BIRTH (month, day, and year) Aug - 1 - 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
66	67	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Painter

(b) General nature of industry, bosiness, or establishment in which employed (or employer) Unknown 50

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Shoemaker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Merchant

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed JUN 29 1927 19 C. HAMPSON JONES, M. D. Registrar

Per K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927 — 15

17 I HEREBY CERTIFY, That I attended deceased from June 25 27, 19.., to June 27 27, 19..,

that I last saw him alive on June 27 19 27

and that death occorred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TBC

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)

(doration) ..yrs. ..mos. ..da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Caldwell, M. D.

6-27 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injory, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reistertown Md. — Date of Burial June 29 19 27

20 UNDERTAKER Wm. Cook — ADDRESS 5076 Liberty

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23488

CERTIFICATE OF DEATH

+ 179 E 23488

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 4-25 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Carney

(a) RESIDENCE NO. Carney, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. 6 ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Thomas Carney

6 DATE OF BIRTH (month, day, and year): July 22 1854

7 AGE: Years 72. Months 11 Days 5 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, professioo or particular kind of work: Housewife

(b) General oature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt. County.

PARENTS

10 NAME OF FATHER: Bernard Garlets.

11 BIRTHPLACE OF FATHER (City or towo) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Mc Dermott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Robert E Carney Carney Md.

15 Filed ..... 19 .....

JUN 29 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, aod year): June 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21 . 1927 . to June 27 . 1927 .

that I last saw h er alive on June 27, . 1927 .

and that death occurred, oo the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia —

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if oot at place of death? —

Did ao operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Thomas B. Turner, M. D.

6-27, 1927 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, aod (2) Whether Accideotal, Suicidal, or Homicidal. (See reverse side for additioaal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery. Date of Burial: Jun 30 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Nayland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23489 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23489

CERTIFICATE OF DEATH. 117

1-PLACE OF DEATH Univ. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Dempsey

(a) RESIDENCE NO. 2429 E. Preston ST., WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Margaret Dempsey

6 DATE OF BIRTH (month, day, and year) March 15th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer M. A. Long

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Dempsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Dempsey (Address) 2429 E. Preston st

15 Filed JUN 29 1927 19 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/26/27, 19 , to 6/26/27, 19 ,

that I last saw him alive on 6/26/27, 19 ,

and that death occurred, on the date stated above, at 9.00 pm.

The CAUSE OF DEATH* was as follows:

appendicitis

peritonitis

(duration) yrs mos 2 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/26/27

Was there an autopsy? No

What test confirmed diagnosis? Operation & Phy Exam

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 3 d 27

20 UNDERTAKER: Geo. F. Roth — ADDRESS: 1735 Harford Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23490

CERTIFICATE OF DEATH.

90 E 23490

REGISTERED NO. 29463

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 25th WARD)

2-FULL NAME James S Ford

(a) RESIDENCE NO. Mt Hope Retreat ST., 25th WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John T Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose A Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Katherine Ruppracht

(Address) 1514 Rutland Ave.

15 Filed JUN 23 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept., 1926, to June 28, 1927, that I last saw him alive on June 27, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Endocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Depressive Psychosis

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Jones, M. D.

6-28-1927 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/30 1927

20 UNDERTAKER Albert L Hilty Jr

ADDRESS 1606 N Chester St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23491

CERTIFICATE OF DEATH.

36 E 23491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Peach St. 27-31 WARD)

2-FULL NAME Vergie Tolson

(a) RESIDENCE NO. 809 Peach ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wash. D. C.

PARENTS

10 NAME OF FATHER: Andrew Tolson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Andrew Tolson

(Address) 529 3rd St S.W. Wash. D.C.

15 Filed JUN 29 1927 C. H. HAMILTON, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to June 26, 1927, that I last saw h[illegible] alive on June 26, 1927, and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Uremia)

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Renal signs

(Signed) C. H. Hamilton, M. D.

6/28 1927 (Address) 201 Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery

DATE OF BURIAL: 6/29 1927

20 UNDERTAKER: John H. Jenkins

ADDRESS: 107 Pine St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23492

CERTIFICATE OF DEATH.

74001

E 23492

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 Longwood ST. 15-61 (WARD) Sr.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Charles Schaderwald

(a) RESIDENCE NO. 2117 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Schaderwald

6 DATE OF BIRTH (month, day, and year) Oct 2-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	76	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Realestate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

I HEREBY CERTIFY, That I attended deceased from June 19, 1927, to June 27, 1927.

that I last saw him alive on June 27, 1927.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No What test confirmed diagnosis? Clinical test

(Signed) S. Lee Magness, M. D.

6/27, 1927 (Address) 1206 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Aug. C. Schaderwald, Jr

(Address) 4518 Maine Ave Montefiello

15 Filed JUN 29 1927 Registrar

C. HAMPSON JONES, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL June 29 1927

20 UNDERTAKER Wm J. Tickner Sons

ADDRESS N. Y. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23493

CERTIFICATE OF DEATH.

129 E 23493

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Robert ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan H. Young.

(a) RESIDENCE NO. 407 Robert ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Young

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE: Years 76 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emma Energ

(Address): 407 Robert St.

Filed JUN 29 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/2, 1927, to 6/26, 1927, that I last saw h[illegible] alive on 6/26, 1927 and that death occurred, on the date stated above, at 5:40 m

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

+ Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. K. Wells, M. D.

6/27, 1927 (Address) 2454 Oak

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Can

DATE OF BURIAL: 6/29/1927

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 630 Druid Park

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23494 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23494

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE (No. ..... St. 23-31 Ward) Registered No. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Snead

(a) Residence No. 1012 Leadenhall St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ? 1861

7-AGE, 66 yrs. — mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Pokomoke Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ? Unknown

14-

(Informant) Peter Snead

(Address) 1012 Leadenhall St.

15-

Filed JUN 29 1927 C. HAMPSON JONES, M. D. Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-27-27

17- I HEREBY CERTIFY, That I attended deceased from 6-13, 1927, to 6-27, 1927,

that I last saw h.. alive on 6-27, 1927,

and that death occurred, on the date stated above, at 12 M. p.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

2 weeks to my knowledge

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

2 weeks to my knowledge

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm A Crook M. D.

, 19 (Address) 65 The Alameda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pomoke city — DATE OF BURIAL, June 30 1927

20-UNDERTAKER, P. L. Brown & Son — ADDRESS 1011 Mount st

P.K.R.

Spec.—1-12-23—M&T—500 Bks.

E 23495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 23495

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 N. Carrolton Ave. ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Dichter

(a) RESIDENCE NO. 221 N. Carrolton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Dichter

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Rae Dichter (Daughter)

(Address) 221 N. Carrolton Ave.

15 Filed JUN 29 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 19 27 to 6/27, 19 27 that I last saw h[illegible] alive on 6/27, 19 27 and that death occurred, on the date stated above, at 12[illegible] P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Right)

(duration) 0 yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hartman, M. D.

6/29, 1927 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew

DATE OF BURIAL 6-29- 27

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Balto. St.,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 23496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Monument & Rutland St. 3-4 Ward)

2-FULL NAME Miss Helen Kreiger

(a) RESIDENCE NO. 1634 E. Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 16-1915

7 AGE: Years 11 | Months 11 | Days 13 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Harry Kreiger

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Nodelblatt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: J. Lewis

(Address): 1739 E. Balto. St.

15 Filed....., 19..... Registrar.....

JUN 29 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to June 29, 1927, that I last saw her alive on 6-29-27, 19....., that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever - Mitral Stenosis

Mitral Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) .....yrs. .....mos. 2 ds.

18 Where was disease contracted — at home

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edmund Levin, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — Date of Burial 6-29 19-27

20 UNDERTAKER: Jos. Levin — ADDRESS 1739 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Emma M Thomson Letter on file from Robt E Fridle M.D. dated 8-2-1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23497

CERTIFICATE OF DEATH.

46 E 23497

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Howard A. Kelly Hospital (St.) (Ward)

2-FULL NAME Mrs. Elbert Thomson

(a) RESIDENCE NO. 3129 Abell Ave (St.), Balto., Md. (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): ~~Married~~

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mrs Elbert Thomson

6 DATE OF BIRTH (month, day, and year): Oct 14. 1852

7 AGE: Years 74 | Months 6 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Haven Conn.

PARENTS

10 NAME OF FATHER: Elias Elizah Mallory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn

12 MAIDEN NAME OF MOTHER: Charlotte Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn

14 Informant: Elbert Thomson (Address) 3129 Abell Ave.

15 Filed JUN 29 1927, 19 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1923, to June 28, 1927, that I last saw h[illegible] alive on June 28, 1927, and that death occurred, on the date stated above, at 9[10] A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Biopsy.

(Signed) Robt E. Fridle, M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: June 30 1927

20 UNDERTAKER: John O Mitchell & Sons — ADDRESS: E. Pl[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 23498

E 23498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. WARD) 5-8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Maltese

(a) RESIDENCE NO. 416 Forrest St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Maltese

6 DATE OF BIRTH (month, day, and year): 11/11. 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31.	7.	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): 057

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Salvatore Rocitra

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Josephine Piacen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Jos Maltese 416 Forrest.

15 Filed JUN 29 1927 C. HAMPSON JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/26 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/21/27, 19, to 6/26/27, 19, that I last saw h alive on 6/26/27, 19, and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis
Chronic appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Embolism

(duration) 6/26/27 yrs. mos. ds.

18 Where was disease contracted (if not at place of death)?

Did an operation precede death? yes Date of 6/22/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) W. Wallace Walker M. D.

19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer

DATE OF BURIAL: 6/30 1927

20 UNDERTAKER: Co. J. Ruth

ADDRESS: 1735 Harford Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23499

CERTIFICATE OF DEATH

90

E 23499

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 East 22nd. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. McCardell

(a) RESIDENCE NO. 222 East 22nd. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (b) WIFE of William E. McCardell Sr.

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 67 Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Timothy Brown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Miss Eunice McCardell

(Address) 222 E. 22nd. Street.

15 Filed JUN 29 1927 19 C. HAMPTON JONES, M. D. Registrar

Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6/27/27

17 I HEREBY CERTIFY, That I attended deceased from 6/27/22 19 to 6/27/27 19

that I last saw h alive on 6/27/27 19

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Ch. Endocarditis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Gaddess M. D.

6/28/27 19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cmetery — Date of Burial: 6/30/27 19

20 UNDERTAKER: Chas F. Braue & Son — ADDRESS: 1108 W Royal ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Malkus

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23500 — 1-PLACE OF DEATH

129 E 23500 — REGISTERED NO.

CITY OF BALTIMORE; (No. 12 Parkave Casey ST. 26-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaretha Malkus

(a) RESIDENCE No. 12 Parkave. Rochsburg ST. ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. ... How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Malkus

6 DATE OF BIRTH (month, day, and year): July 13th 1850

7 AGE: Years 76. Months 11. Days 15. If LESS than 1 day, hrs or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: None.

9 BIRTHPLACE (city or town) (State or country): Bavaria. Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria Germany

14 Informant: John Malkus

(Address) 17 Park ave. Rochsburg

15 Filed JUN 29 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 30 1927, to June 27 1927.

that I last saw h[e] alive on June 27 1927.

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Organic Myocardial Disease of the Heart

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Intestinal Nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Edward C.E. Gogler, M. D.

, 19 (Address) 5518 Harford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 1 1927

20 UNDERTAKER: Frederick Rossalm & Sons — ADDRESS: Fulton

C. HAMPSON JONES M.D.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23501

CERTIFICATE OF DEATH.

E 23501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U. S. Marine Hospital No1.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 12-51 WARD)

2-FULL NAME Clarence Keeler

(a) RESIDENCE NO. 3100 St Lawrence ave ST., WARD

(Usual place of abode) Richmond Va

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully scrutinized. Any error or omission CAUSE OF DEATH is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY in plain terms so that it may be properly classified. A false statement of OCCUPATION

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE: Years 24 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer S/S Dora Weems

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Balt & Carolina S S Co.

(Address)

15 Filed JUN 28 1927, 19 Per R.H. Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1927, to June 28, 1927, that I last saw him alive on June 28, 1927 and that death occurred, on the date stated above, 8 a.m.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? S.S. Dora Weems

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical findings & laboratory tests

(Signed) C. L. Wilmot, M. D.

, 19 (Address) U.S Marine Hospital No 13 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Virginia — DATE OF BURIAL June 29, 1927

20 UNDERTAKER E. Leroy Stiffler — ADDRESS 125 E. North ave.

Spec.—12-9-25—A Co.—200 Bks.

E 23502 (1927 E 2343)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Whitted

(a) RESIDENCE NO. 1229 Madison St. Ave Ward City

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Chester Whitted

6 DATE OF BIRTH (month, day, and year) ~~April 6~~ Oct 6 - 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country) Md

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Prince Geo. Co. Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ....., 19 ..... 17 Registrar

C. HAMPSON JONES, M. D.

N 20 1927 Per RPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1927

17

I HEREBY CERTIFY, That I attended deceased from June 25 1927, to June 28, 1927, that I last saw her alive on June 28, 1927, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Spinal Cord Tumor

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Post operative Shock

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? Yes Date of June 27 '27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Warfield M Theobald, M. D.

, 19 (Address) 1416

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial June 30 27

20 UNDERTAKER Pearce & Edgerly ADDRESS 364 W. Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23503

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23503

CERTIFICATE OF DEATH.

161-001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-12 Ward)

2-FULL NAME Baby Webster

(a) RESIDENCE NO. 945 N. Chester St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word)

5A If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1927

7 AGE Years Months Days 5 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Artie Lee Webster

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rita L. Webster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records Johns Hopkins Hospital.

(Address)

15 Filed ... C. HAMPSON JONES, M. D. Registrar

JUN 29 1927 Per 1492 ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1927, to June 3, 1927

that I last saw her alive on June 3, 1927,

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY —

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23504

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23504

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp St. 21-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Page

(a) RESIDENCE NO. 569 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Cd	S

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Francis Chappell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant
(Address)

15 Filed , 19 Per 1196 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/13, 1927, to 6/22, 1927, that I last saw her alive on 4/22, 1927 and that death occurred, on the date stated above, at 1200 11 m.

The CAUSE OF DEATH* was as follows:

Endocarditis Aortic insufficiency
Cardiac hypertrophy & dilatation
Congestive failure

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) L. F. Lowry, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

C. HAMPSON JONES, M. D.

JUN

N 29 1927

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23505

E 23505

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospital St. 4-25 WARD)

2-FULL NAME Mary Jane Castle

(a) RESIDENCE NO. 6665 Vine St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Cornell

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 56 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jno Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Nancy Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs J Butler 908 Pitcher St

15 Filed ....., 19 ..... Registrar

JUN 29 1927

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/22, 1927 to 6/27, 1927 that I last saw h alive on 6/27/27, 1927 and that death occurred, on the date stated above, at 8 40P m.

The CAUSE OF DEATH* was as follows:

Hopelessness - Left side Hemiplegia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Terminal pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. Elliott M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 6/30 1927

20 UNDERTAKER: Daniel Easton

ADDRESS: 716 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-27—M&T—500 Blks.

E 23506 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23506

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH West Balto General Hospital REGISTERED NO. 23-31

CITY OF BALTIMORE: (No. Reynor and Dukeland ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Winston

(a) RESIDENCE NO. 114 Rogers Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Yes.

5a If married, widowed, or divorced HUSBAND of or) WIFE John Winston

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mary Reddick 1631 Ostend St

15 Filed JUN 29 1927 Ret. C. HAMPSON JONES, M. D. Registrar APR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/27/27, 19 , to 6/27, 19 27 that I last saw her alive on 6/27, 19 27 and that death occurred, on the date stated above, at 2:30 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. 2/ ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL 6/30 1927

20 UNDERTAKER Edward Toulson ADDRESS 708 Woodbine Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

E 23507 HEALTH DEPARTMENT—CITY OF BALTIMORE 21 E 23507

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Penn St ST.; 17-26 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James ~~Sherkliff~~ - Sherkel.

(Residence in Baltimore: No. 818 Penn St. St.: 22 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Col.	Married

6-DATE OF BIRTH, Nov. 12, 1876. (Month) (Day) (Year)

7-AGE, 50 7 16 — 49 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or ....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer): 174

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Sherkel

(Address) 818 Penn St

15-

Filed ....., 191.... Registrar.

N 29 1927 RRA

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1927. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1927, to June 28 1927, that I saw him alive on June 28 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia

(Duration) yrs. 2 mos. 4 ds.

(Signed) John A. Delaney M. D.

191... (Address) 1831 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, July 1, 1927

20-UNDERTAKER Daniel Easton ADDRESS 916 Penn

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 23508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23508

CERTIFICATE OF DEATH

31

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. B-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lockwood

(a) RESIDENCE NO. 113 Albemarle st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, bosiness, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Lockwood

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Conn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

C. THOMPSON JONES, M. D.

Registrar

JUN 29 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20 19 27 to June 29 19 27

that I last saw him alive on June 29 19 27

and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (doration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? by autopsy

(Signed) W. E. Gaither M. D.

6-29-27 (Address) Balto. CITy Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

Date of Burial June 30 1927

20 UNDERTAKER J. M. Cook

ADDRESS 505 E Monument

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23509

CERTIFICATE OF DEATH.

3 1 E 23509

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 658 Sarah Ann St. 25 Ward)

2-FULL NAME Edith Saunders

(a) RESIDENCE NO. 658 Sarah Ann St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Not known

14 Informant Lea Cann

(Address) 658 Sarah Ann - St

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

N 29 1927 Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above on an ~~June 28~~ 27 (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said _____ (Inquest, autopsies or inquiry.)

Highley

find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul TB

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Laundry

(duration) 1 yrs. ____ mos. ____ ds.

June 28/27 (Signed) G E Frank M. D.

(Coroner)

(Address) 143 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sent to Md Date of Burial June 30/27

20 UNDERTAKER Sandy Bodenheimer ADDRESS 846 Pa ave

Edward Easton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the above information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23510 | CERTIFICATE OF DEATH. | E 23510

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 William ST. 22-33 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Seymour

(a) RESIDENCE NO. 819 William St ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Seymour

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) / / 6/27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cath. Corbett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Thos Seymour
(Address) 819 William St

15 Filed JUN 29 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per .....

N 29 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to June 27, 1927,
that I last saw h alive on June 27, 1927
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 0 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell, M. D.

6/29 1927 (Address) 1709 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 30 1927
20 UNDERTAKER F. A. Wanserson	ADDRESS 703 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23511

HEALTH DEPARTMENT—CITY OF BALTIMORE

1094 002

E 23511

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) ST. 27-55 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sweiger (SWEIGER)

(a) RESIDENCE NO. 400 W Rogers Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1878

7 AGE — Years: 49 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 63

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Sweiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Schaare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carroll Sweiger (Address) 722 E. 41st Street

15 Filed N 29 1927 19 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 7:30 P.M. 6/27. 1927. to 10:10 P.M. 6/27. 1927.

that I last saw him alive on 6/27, 1927

and that death occurred, on the date stated above, at 10:10 P m.

The CAUSE OF DEATH* was as follows:

Vincents, Inguinal Infection & throat

(duration) yrs. 5 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? apparently at business

Did an operation precede death? Yes Date of 2/7/27

Was there an autopsy? ~~Yes~~ No

What tests confirmed diagnosis? Smear

(Signed) R. L. Anderson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 30 27

20 UNDERTAKER: Fred. A. Krauss & Co — ADDRESS: 703 Hamm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23512

CERTIFICATE OF DEATH. X 143-002

E 23512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD 30

2-FULL NAME Ethel Bond.

(a) RESIDENCE NO. Sykes Villa Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female.

4 COLOR OR RACE Black.

5 Single, Married, Widowed, or Divorced. (write the word) Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Milton Bond

6 DATE OF BIRTH (month, day, and year) Jan. 26 1899

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) — 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Fournier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hickwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Milton Bond (Address) Sykesville Md

15 Filed JUN 30 1927. C. HAMPSON JONES, M.D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/15/ 1927. to 6/29/ 1927.

that I last saw her alive on 6/29/ 1927.

and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Ruptured ectopic pregnancy

(duration) — yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Post operative intestinal obstruction.

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6/21/27

Was there an autopsy? No

What test confirmed diagnosis? Obs Exam. Operation

(Signed) Dwight Reynolds, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sykesville Md. DATE OF BURIAL July 2 1927

20 UNDERTAKER Reed Funeral ADDRESS Sykesville Md

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23513

CERTIFICATE OF DEATH.

129 E 23513

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 2267 N Bedford St., 11-15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Jackson

(a) RESIDENCE NO. 2267 N Bedford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced — HUSBAND of or) WIFE of: Geo. T. Jackson

6 DATE OF BIRTH (month, day, and year): Aug 15 187[illegible]

7 AGE: 51 Years 53 | Months 10 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Richard Booker

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: Maria Sawcat

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Alfred Booker 342 Dolphin St

15 Filed JUN 30 1927 — C. HAMPSON JONES, M. D. Registrar — RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to June, 1927, that I last saw h[illegible] alive on June 27, 1927 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Evans

(Signed) Frank E. Magnus M. D.

June 29, 1927 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: June 30 1927

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 2[illegible] N Bedford

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

Blanche Lee.

E 23514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 102 E 23514

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4300 Arch ST., 11 WARD) REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Lee

(a) RESIDENCE NO. 4300 Arch ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Lee

6 DATE OF BIRTH (month, day, and year) 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Jerry F. Chandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Mary Cloud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alvin Leland (Address) 430 Arch St

15 Filed JUN 30 1927 HAMPSON JONES, M. D. Registrar Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 17th 1927 to June 28th 1927 that I last saw h alive on June 26th 1927 and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.

(Duration) 1 wk. mos ds.

CONTRIBUTORY (Secondary) Phimosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chi, M. D.

(Address) 924 Mosher ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 30 1927

20 UNDERTAKER Samuel Kennedy ADDRESS 1 E Saratoga St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23515

CERTIFICATE OF DEATH

162

E 23515

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 714 S Montford Ave St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Drgos

(a) RESIDENCE NO. 714 S Monford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 29 1927

7 AGE — Years — Months — Days — IF LESS than 1 day, 12 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Stefan Drgos

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Koniecara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Stefan Drgos

(Address) 714 S Monford Ave

15 Filed JUN 30 1927 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 29 1927 to June 29 1927

that I last saw him alive on June 29 1927

and that death occurred, on the date stated above, at 10 30a m.

The CAUSE OF DEATH* was as follows:

Acute Atasia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rysanek M. D.

June 29 1927 (Address) 805 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary June 30 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23516
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 23516
REGISTERED NO.

City of BALTIMORE: (No. 1026 Leadenhall St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie McKenzie

(a) RESIDENCE NO. 1026 Leadenhall St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe
4 Color or Race: Col
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John McKenzie

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 51 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Public Laundry
(c) Name of employer: Elite Laundry

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS
10 NAME OF FATHER: Thomas Dennis
11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md
12 MAIDEN NAME OF MOTHER: Mary Blackstone
13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: David McKenzie
(Address): 1026 Leadenhall St.

15 Filed JUN 30 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to June 27, 1927, that I last saw h.. alive on June 27, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions
(duration) 7 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Interstitual Nephritis
(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted: ?
If not at place of death!
Did an operation precede death! no Date of
Was there an autopsy? no
What test confirmed diagnosis!
(Signed) D. T. Hamrick, M. D.
6/29 1927 (Address) 805 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial: July 1 1927

20 UNDERTAKER: I. L. Brown's Son ADDRESS: 107 W. Monument

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 23517

REGISTERED NO.

E 23517

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltcity Hospital 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma White

(a) RESIDENCE NO. 411 New St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. White.

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years: 58 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

C. HAMPSON JONES, M. D.

15 Filed JUN 30 1927 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 27, 1927, that I last saw h[illegible] alive on June 27, 1927, and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Consumption 2
Rt Pleurisy 2 metastases 2

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) [illegible], M. D.

, 19 (Address) Baltcity Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: June 30 1927

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 416 N. Carolina St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

R Hooper Gill

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23518

CERTIFICATE OF DEATH

X 135 E 23518

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R Hooper Gill

(a) RESIDENCE NO. Upper Co Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855-3-1

7 AGE Years 72 Months 3 Days 29 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rasto Co Md

(State or country)

PARENTS

10 NAME OF FATHER Richard Gill

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant

(Address) Hospital Records

15 Filed 19

Registrar

E. CAMPBELL JONES, M. D.

JUN 30 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/25/27 to 6/30/27

that I last saw h[illegible] alive on 6/30/27 at P. 20a m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Uremia 27

Hypertrophy prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Urethra

Hydrocele (duration) yrs. mos. 4? ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Chemist

What test confirmed diagnosis?

(Signed) W. S. Simpkins M. D.

(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Md Date of Burial July 2 1927

20 UNDERTAKER Edw C Tipton ADDRESS Hampstead Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23519

CERTIFICATE OF DEATH.

X 181-001 E 23519

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 N.High St. St., 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Caulfield.

(a) RESIDENCE NO. Oak Park Ill. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ;--------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
36	36	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Illinois.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant H.L.Lindner.

(Address) 81 Mosher St.

15 Filed JUN 30 1927 19 JAMES COOPER, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas asphyxia.
Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signature (Coroner) M. D.

6/29, 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Greggsville, Illinois June 30 192 7

20 UNDERTAKER ADDRESS

John A. Denny 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

Weinraub

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 23520

E 23520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital - Ward) 9

2-FULL NAME Selma Weinraub

(a) RESIDENCE NO. 1914 E. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 3 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 4 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 1915

7 AGE: Years 12 | Months 5 6 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER Solomon Weinraub

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER Rosa Weinraub

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Samuel Kraffel

(Address) 1431 E Baltimore St

15 Filed JUN 30 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to June 29, 1927,

that I last saw h W alive on June 29, 1927,

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Shock (Post operative)

(duration) yrs. 2 hours

18 Where was disease contracted

If not at place of death

Did an operation precede death? Yes Date of June 27, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) John A. Askin, M. D.

6/29, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — Date of Burial 6/30 1927

20 UNDERTAKER: Sol Levin & Bro — ADDRESS 1127 E Balto St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

H. HAMPSON JONES, M.D.

Per

Spec.—1-10-21—M&T—1500 Bks.

E 23521 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

38 E 23521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 May St ST., 5-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Soloman Dsons

(a) RESIDENCE No. 1416 E. May ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Dsons

6 DATE OF BIRTH (month, day, and year) Jan 12 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lincoln Co Georgia

PARENTS

10 NAME OF FATHER Armstead Dsons

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Addis Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15 1927 to June 29 1927

that I last saw h[illegible] alive on June 28 1927

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ww

Did an operation precede death? ww Date of

Was there an autopsy? ww

What test confirmed diagnosis? Physical

(Signed) Jorge J. Allen M. D.

(Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Ada Dsons (Address) 1416 E. May St

15 Filed JUN 30 1927 T. C. HAMILTON JONES, M. D. Registrar

Per

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

20 UNDERTAKER Byron & Wright

DATE OF BURIAL 6/30 1927

ADDRESS 1218 Mc Elderry St

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

E 23522

CERTIFICATE OF DEATH.

E 23522

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital, St., 12 Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Archer Bell.

(a) RESIDENCE NO. 8219 N. Calvert St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXXXXX E. May Bell.

6 DATE OF BIRTH (month, day, and year) June 21, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Registrar.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John A. Bell,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret J. Bunting,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant E. May Bell. (wife)

(Address) 8219 N. Calvert St.

15 Filed JUN 30 1927, 19 C. HAMPTON MOYER, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage. Struck and knocked down by an automobile truck while crossing the street. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto R. Reinhardt M. D. (Coroner)

6/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

St. Paul & Lexington Sts. June 27, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 6/30 1927

20 UNDERTAKER Wm Cook ADDRESS 5011 North

A. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 23523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001 E 23523

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 S. High St., 3-5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelo Pente

(a) Residence No. 222 S High St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Mrs. Rosa Pente

6-DATE OF BIRTH (month, day and year) April 5, 1854

7-AGE 73 74 yrs. 2 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Mechanic 31

(b) General nature of industry, business, or establishment in which employed (or employer). Locks & Engine Repairing

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS:

10-NAME OF FATHER, Nicholas Pente

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Anella - not known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Nicholas J. Pente - Son

(Address) 222 S. High St.

15- Filed JUN 29 1927 C. HAMPSON JONES, M. D. Registrar.

Per R.A.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 29, 1927

17- I HEREBY CERTIFY, That I attended deceased from June 28 1927 to June 29 1927

that I last saw h[illegible] alive on June 29 1927

and that death occurred, on the date stated above, at 11:00 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) yrs. Not known mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Scagnetti M. D.

19 (Address) 244 S Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. July 2 1927

20-UNDERTAKER. Wendell Ryffel & Son ADDRESS 872 Hanover

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23524

CERTIFICATE OF DEATH.

161-60

E 23524

1-PLACE OF DEATH Franklin Square Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No.) Fayette & Calhoun Sts. (If death occurred in a hospital or institution, give its NAME instead of street and number.) WARD 23

2-FULL NAME Baby Charles Voll.

(a) RESIDENCE NO. 702 N Arlington Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jun 27/27

7 AGE: Years — Months — Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Voll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Edna Bevan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Charles Voll
(Address) 702 Arlington ave

15 Filed JUN 30 1927 19 THAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from 6/27/27. 19 to 6/29/27. 19
that I last saw him alive on 6/29/27. 19
and that death occurred, on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. W. Walker M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jun 30 1927

20 UNDERTAKER: Geo. F. Rutt ADDRESS: 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

E 23525

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23525

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 811 N. Stricker St. 16 Ward 22)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Bozeman

(a) RESIDENCE NO. 811 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11-1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	56	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Mary Sugars

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Sarah E. Lewis

(Address) 811 N. Stricker

15 Filed JUN 30 1927 C. HOWARD HOLLINGSWORTH, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to June 28, 1927.

that I last saw h[illegible] alive on June 28 1927

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. M. Hatcher, M. D.

6/29 1927 (Address) 1205 Pa Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — Date of Burial July 1st 1927

20 UNDERTAKER Lemmon Chase Son ADDRESS 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23526 E 23526

CERTIFICATE OF DEATH.

75-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No.) Raynn and Dukeland ST. 13-59 WARD 19

2-FULL NAME Annie Mason

(a) RESIDENCE NO. 2304 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 2, 1887

7 AGE: Years 40. Months 5 Days 25 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic. 070

(b) General nature of industry, business, or establishment in which employed (or employer): at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Leesburg Co Va.

PARENTS

10 NAME OF FATHER: Charles mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Alice Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Matilda Mason. (Address) 2304 McCulloh St.

15 Filed JUN 30 1927 Per R.K.

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/27 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6/16/27, 19 , to 6/27, 1927, that I last saw her alive on 6/27, 19 27 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

:

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) acute paralytic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. Gen.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Luckett P.O. Va — DATE OF BURIAL: July 1 1927

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Eierstman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23527

CERTIFICATE OF DEATH

100-001

E 23527

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp. 7-13

City of BALTIMORE: (No. 33rd & Calvert St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kline

(a) RESIDENCE NO. 2031 E. Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1925

7 AGE Years 2 Months 4 Days 10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John H. Kline

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balt., Md.

12 MAIDEN NAME OF MOTHER Mary Gilmore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt., Md.

14 Informant Mother

(Address) 2031 E. Eager St

15 Filed JUN 30 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1927, to June 30, 1927,

that I last saw him alive on June 30, 1927,

and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) James Arthur Weinberg, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial July 2nd 1927

20 UNDERTAKER Geo. M. Smith Son ADDRESS Eutaw & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Deetsoff - 2020 N Charles St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23528

CERTIFICATE OF DEATH.

3 1

E 23528

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2430 Callow Ave ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Kirk

(a) RESIDENCE NO. 2430 Callow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie H Kirk

6 DATE OF BIRTH (month, day, and year): Sept 24 1899

7 AGE: Years 27 Months 9 Days 5 If LESS than 1 day, ... hrs. or .... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Secht & Co

9 BIRTHPLACE (city or town) (State or country): Salto Md

PARENTS

10 NAME OF FATHER: William H Kirk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salto Md

12 MAIDEN NAME OF MOTHER: Katherine E Kendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Salto Md

14 Informant: Nellie H Kirk (Address) 2430 Callow Ave

15 Filed ..... 19 .....

JUN 30 1927

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to June 29, 1927, that I last saw him alive on June 29, 1927 and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Probably Philadelphia Pa

Did an operation precede death? X Date of X

Was there an autopsy? No

What test confirmed diagnosis? Sputum + T.B.

(Signed) E W Deetsoff M. D.

6/30/1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Faith Presbyterian — DATE OF BURIAL: July 2 1927

20 UNDERTAKER: Wilson Cook — ADDRESS: 503 E Northern

INSTRUCTIONS: Answer questions carefully and completely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 23529

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33rd + Calvert St. St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Byard Baker

(a) RESIDENCE NO. 110 Wilkens St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) June 6, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	—	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Jacob B Baker

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Summer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

by

JUN 30 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 27 to June 29, 19 27 that I last saw him alive on June 29, 19 27 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 110 Wilkens St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory methods

(Signed) Hanbah Smith, Jr. M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grosonville, Queen Anne Co. Date of Burial June 30 19 27

20 UNDERTAKER W. M. Cook ADDRESS 500 E Fayette

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23530 — 129 — E 23530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 E. Baltimore ST., 2-4 WARD)

2-FULL NAME Augustine J. Ryan

(a) RESIDENCE NO. 1825 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) May 24, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	59	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President

(b) General nature of industry, business, or establishment in which employed (or employer) National Coal Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Timothy Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary W. Shortall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Timothy Ryan (Address) 1825 E. Baltimore St.

15 Filed JUN 30 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/27 1927 to 6/28 1927

that I last saw h live on 6/28 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis - Hypertrophied Heart -

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Poisoning -

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Timmy — M. D.

6/29 1927 (Address) 622 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/1 1927

20 UNDERTAKER Henry W. Peabody & Son

ADDRESS 805 N. Calvert

IMPORTANT. Should be filled out, signed, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 23531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3M E 23531

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (C.H.) St. 5-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boris Lois

(a) RESIDENCE NO. 4 Cereal st., Curtis Bay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Frank Lois

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Lemis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital Records

(Address)

15 Filed JUN 30 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 27, to June 28, 19 27, that I last saw him alive on June 28, 19 27, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TBC

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. E. Eatlem, M. D.

6-28-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross July 1 — 27 19

Date of Burial

20 UNDERTAKER J. W. Ozazewski ADDRESS 1830 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23532 129 E 23532

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Stewart

(a) RESIDENCE NO. 1911 Wheeler St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector for

(b) General nature of industry, business, or establishment in which employed (or employer) State Roads

(c) Name of employer State of Maryland

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Dr. W. J. Stewart

11 BIRTHPLACE OF FATHER (City or town) St. Mary's Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Hall

13 BIRTHPLACE OF MOTHER (city or town) Rock River

(State or country) Md

14 Informant George Stewart

(Address) 1911 Wheeler Ave.

15 Filed NOV 30 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 29 - 27

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1927, to June 29, 1927, that I last saw him alive on June 29, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis & Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia —

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? none.

What test confirmed diagnosis?

(Signed) Clement R. Thomas, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial July 1/27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WARREN, Successor) ADDRESS 106 W. NORTH AVE.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23533

E 23533

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. (or) WARD) 28th

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elbert M. Davis

(a) RESIDENCE NO. Mount Hope Retreat ST., 28th WARD

(Usual place of abode) (If not a resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Davis -

6 DATE OF BIRTH (month, day, and year) ?.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt 40 (?)	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Laboring -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Preston Md -

PARENTS

10 NAME OF FATHER Wm J. Davis -

11 BIRTHPLACE OF FATHER (city or town) Seaford (State or country) Del -

12 MAIDEN NAME OF MOTHER Melvia Blades

13 BIRTHPLACE OF MOTHER (city or town) Preston (State or country) Md

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md -

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1925, to June 29th, 1927, that I last saw H[e] alive on June 23rd, 1927, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Paresis - Specific

over (duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation over (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md (?)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wassermann ++++

(Signed) Frank J Hanney, M. D.

June 29, 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Preston, Caroline Co, Md.

DATE OF BURIAL June 30 27

20 UNDERTAKER C. HAMPSON JONES, M. STEWART & MOWEN COMPANY Successor

ADDRESS 108 W. MULBERRY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23534

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23534

CERTIFICATE OF DEATH

REGISTERED NO. 73

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 26-36 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Imla

(a) RESIDENCE NO. 14 S. 12 & 9 Ch Ave. Ward

(Usual place of abode) Canton (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Imla.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER David Imla

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed ....., 19.... Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/2 8/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 2, 1927

that I last saw h[illegible] alive on June 2, 1927.

and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Ascending Paralysis -

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Tumor of Vertebra Cervicalis

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Scale

(Signed) C. Hudson Jones, M. D.

(Address) CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. Date of Burial July 1 1927

20 UNDERTAKER Wm C. Miller & Son ADDRESS 2334 E. Lan[illegible]

JUN 30 1927

C. HUDSON JONES M.D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23535

CERTIFICATE OF DEATH.

170 E 23535

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 W. Franklin St. Ward 9-25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Haessler

(a) RESIDENCE NO. 640 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1872

7 AGE: Years 60 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dairy Lunch

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country) Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant P. O. Det. Police

(Address) Central Station

Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries received in fall from

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed C. H. Jones M. D.

(Coroner)

Dated January 7, 19 27 Address 28 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER

ADDRESS

JAN 30 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23536

CERTIFICATE OF DEATH

E 23536

REGISTERED NO. 17

1-PLACE OF DEATH

City of BALTIMORE: (No. Md general Hospital St. 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Morris

(a) RESIDENCE NO. 921 Grandby St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1859

7 AGE: Years 67 Months 7 Days 5 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New-york

(State or country) N. Y.

PARENTS

10 NAME OF FATHER John Morris

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz McEvoy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

C. H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-28- 1927, to June 19 1927

that I last saw h~~im~~ alive on June 19, 1927,

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Chr Cholecystitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 6-16-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Hampsons, M. D.

19 (Address) 811 N. Eu Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23537

E 23537

CERTIFICATE OF DEATH

74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 E Eager ST. 7-13 WARD)

2-FULL NAME William H. Franke

(a) RESIDENCE NO. 1718 E Eager ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day and year) Oct 14-1855

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	71	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Stillman
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer Standard Oil Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Franke

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) dont know

14 Informant Mrs Elizabeth Vogeley
(Address) 1718 E Eager St

15 Filed JUN 30 1927, 19.. C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7th 1927, to June 29th, 1927, that I last saw her alive on June 29th, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted (if not at place of death) .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S. Stillman, M. D.

June 29, 19 27 (Address) 1801 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL July 1 1927

20 UNDERTAKER D. George W Junkin

ADDRESS 1737 E Eager St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23538

23538

CERTIFICATE OF DEATH

31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (T. B. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Peterson

(a) RESIDENCE NO. 211 Spring st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Peterson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

1498 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 5 19 27 to June 26 19 27

that I last saw h im alive on June 26 19 27

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TBC

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. E. Cutting M. D.

6-26-27 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

C. HAMPSON JONES, M. D.

Commissioner of Health

JUN 30 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23539

E 23539

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 76-37 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Miller.

(a) RESIDENCE NO. B. C. H. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 65 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 21 D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records.

15 Filed . 19 C. HAMPSON JONES, M. D.

Registrar

Per 1499 RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1927 to June 27, 1927.

that I last saw her alive on June 27, 1927

and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

acute

Arteriosclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) C. Holmes Lloyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interred and buried in Loudon Park Cem. Date of Burial July 6, 1927

20 UNDERTAKER David Easton 9/6 29 ADDRESS City.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 23540

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23540

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Garner

(a) RESIDENCE NO. C. C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Resident

15 Filed JUN 30 1927 19 C. HAMPSON JONES, M. D. Registrar

Per 1500 NEW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923 to June 26, 1927 that I last saw h. alive on June 26, 1927 and that death occurred, on the date stated above, at 10.00 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) C. Hampson Jones M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23541

E 23541

CERTIFICATE OF DEATH

159

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernadette M. Brown

(a) RESIDENCE NO. 1212 Hanover St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 29, 27

7 AGE — Years — Months — Days

IF LESS than 1 day.... hrs. or .... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Frank Brown

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Carrie Larkins

13 BIRTHPLACE OF MOTHER (city or town): Balto Md

(State or country)

14 Informant: Mrs. Frank Leonard

(Address) 1212 Hanover St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 - 27 19

17 I HEREBY CERTIFY, That I attended deceased from June 29, 19 27, to June 29, 19 27,

that I last saw h[illegible] alive on June 29, 19 27,

and that death occurred, on the date stated above, at - 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Status Cerebrus

(duration) yrs. mos. 1 hr ds.

CONTRIBUTORY (Secondary) Premature Birth.

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

19 6/30/27 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

Date of Burial: June 30 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS 1402 Light St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAMISON JONES M.D.

JUN 30 1927

Cor.—12-9-25—A Co.—200 Bks.

E 23542

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 Hanover St. St. 21-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward T. Curran.

(a) RESIDENCE NO. 817 W. Lombard St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 10, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore? Md.

PARENTS

10 NAME OF FATHER James J. Curran.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah A. Gillooly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant James J Curran. (brother)

(Address) Mamaroneck, N. Y.

15 Filed JUN 30 1927, 19

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

6/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Balto. Md. Date of Burial July 1 1927

20 UNDERTAKER F. A. Weaver & Son ADDRESS 703 Fawn St

Dist. RPS

Spec.—1-12-23—M&T—500 Blks.

E 23543

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-E 23543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 W. Pratt St. 27-30 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Zinks

(a) RESIDENCE NO. 405 W. Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Zinks

6 DATE OF BIRTH (month, day, and year): Dec 8 - 1849

7 AGE: Years 77 Months 8 Days 21 27 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Gerhart Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Rolfes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Hans (Address) 405 W. Pratt st

15 Filed ..... 30 1927 ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/29 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6/24/27, 19..... to 6/29, 19 27

that I last saw h alive on 6/28, 19 27

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. J. Gray M. D.

6/29, 19 27 (Address) 622 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hoy Redeemer — DATE OF BURIAL: July 2 19 27

20 UNDERTAKER: F. A. Schaueckeau — ADDRESS: 703 Hanover st

SCOPE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23544 E 23544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Carolinia Apt

CITY OF BALTIMORE: (No. 120 W University Parkway ST. 12-51 WARD) REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eugenie Martin

(a) RESIDENCE No. 120 Univers'ty Parkway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of ~~late~~ G. H. Martin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Corlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth England

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. Sarah Martin

(Address): University Parkway

15 Filed JUN 30 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to June 30, 1927.

that I last saw her alive on June 28, 1927

and that death occurred, on the date stated above, at 7 a m

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and chronic myocarditis

(duration) many yrs. — mos. — ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) — yrs. — mos. few ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. Hurtt, M. D.

6/30 1927 (Address) 712 Park Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem'y — DATE OF BURIAL: July 2 1927

20 UNDERTAKER: Henry H. Jenkins Sons Co. — ADDRESS: [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23545 × 23 E 23545

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 12-44

City of BALTIMORE: (No. 33rd & Calvert St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Arthur M. Field (Isabella)

(a) RESIDENCE NO. 58 Grove St., Asheville North Carolina St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Arthur M. Field

6 DATE OF BIRTH (month, day, and year) April 5, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	59	2	25	

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rome, (State or country) N.Y.

PARENTS

10 NAME OF FATHER ? Field

11 BIRTHPLACE OF FATHER (City or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Sara A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rome N.Y.

14 Informant (Son) Mr. Marcus Field (Address) Asheville N.C.

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

Per RRH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to June 30, 1927, that I last saw her alive on June 30, 1927, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis.

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 24, 1927

Was there an autopsy? No

What test confirmed diagnosis? History, Physical Signs

(Signed) J. [illegible] Geraughty, M. D.

6/30 19 27 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rome N. Y. Date of Burial July 1st 1927

20 UNDERTAKER Henry H. Eustis Sons ADDRESS McElliott & Orchard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA very important. See instructions on back of certificates.

JUN 30 1927 C. HAMILTON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 23546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 23546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3105 Dwyers Falls Pkway (St.) (Ward) 15-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Rockefellow Crane

(a) RESIDENCE NO. 3105 Dwyers Falls Pkway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adolphus P. Crane

6 DATE OF BIRTH (month, day, and year): Sept. 1, 1847

7 AGE — Years: 79 | Months: 10 | Days: 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Stafford Co Va

PARENTS

10 NAME OF FATHER: Jacob F. M. Rockefellow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Frances Wheland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mr. Wm. R. Crane

(Address): 3105 Dwyers Falls Pkway.

15 Filed JUN 30 1927, 19 — C. HAMPSON JONES, M. D. — RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25 , 1927 , to June 29 , 1927 , that I last saw her alive on June 28 , 1927 , and that death occurred, on the date stated above, at 9.0[illegible] a m.

The CAUSE OF DEATH* was as follows:

acute Cardiac Dilatation

Rheumatism

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Lorch Weeks Fox, M. D.

6/30, 1927 (Address) 20 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park Cem. — DATE OF BURIAL: July 1 1927

20 UNDERTAKER: Wm J. Pickerdons. — ADDRESS: North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23547

CERTIFICATE OF DEATH.

60-001 E 23547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1900 N. Payson ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Virginia Brooks

(a) RESIDENCE. No. 1900 N. Payson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 6. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57 58	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw Hat maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Brigham Hopkins Co

9 BIRTHPLACE (city or town) (State or country) Balto Md U.S.A.

PARENTS

10 NAME OF FATHER Henry Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rebecca Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rose E. Morrison
(Address) 1900 N Payson St

15 Filed JUN 30 1927 19 C. HAMPSON JONES, M. D. Registrar
Ref. A.K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1927. to June 29, 1927.
that I last saw her alive on June 28, 1927.
and that death occurred, on the date stated above, at 7.30 A. m.
The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Toxic Goitre

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

6/30/1927 (Address) 3014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 1 1927
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23548

CERTIFICATE OF DEATH.

6-29 74-001

E 23548

1-PLACE OF DEATH

City of BALTIMORE: (No. 1172 Washington Boulevard Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Smoot

(a) RESIDENCE NO. 1172 Washington Boulevard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 78 Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Frank Potee

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: William Smoot

(Address): 1172 Washington Blvd

15 Filed: 1927 C. HAMPSON JONES, M. D.

By: Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) and from information received from Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. at once mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Hortin M. D.

(Corner)

June 29 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: July 7 1927

20 UNDERTAKER: Joseph B Cook ADDRESS: 1003 W Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23549

CERTIFICATE OF DEATH

3/ E 23549

1-PLACE OF DEATH

City of BALTIMORE: (No. 341 S. Monroe St., 19-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Smardon

(a) RESIDENCE NO. 341 S. Monroe St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 16, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	23	6	13 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) Oppenheimer

(c) Name of employer Oberndorf & Co., Inc

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Grant U. Smerdon

11 BIRTHPLACE OF FATHER (City or town) Balto. Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Grace

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant George Smardon

(Address) 341 S. Monroe St.

15 Filed ..... 19 .....

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1927, to June 29, 1927,

that I last saw him alive on June 27, 1927,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Endocarditis

(duration) yrs. 4 mos. 29 ds.

CONTRIBUTORY (Secondary) Pulmonary Trauma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert E. Roberts, M. D.

6/29/27 (Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	7/2/27 19

20 UNDERTAKER Joseph B. Cook

ADDRESS 1002 W. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HARRISON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23550

CERTIFICATE OF DEATH.

18-003

E 23550

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. Ward 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas L. Doyle

(a) RESIDENCE NO. 2543 W. North Ave. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1923.

7 AGE — Years: 4 — Months: 5 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Walter E. Doyle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Kathleen Doyle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Walter E. Doyle

(Address) 2543 W. North Ave.

15 Filed 1926 16 [illegible] Registrar

30 1921

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of right leg. (Automobile accident)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) cerebral embolism.

(duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D.

(Coroner)

1927 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.... yrs.,.... mos.,.... ds. In the State.... yrs.,.... mos.,.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 1/31 192

20 UNDERTAKER Joseph H. Farley ADDRESS Fulton & Edgar

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 23551

E 23551

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frank

(a) RESIDENCE NO. Baltimore City Hospitals St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Frank

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lizzie Baker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed C. HARRISON JONES, M. D. Registrar

JUN 30 1927 Per ARB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 9 19 27 to June 23, 1927 19

that I last saw him alive on June 23, 1927 19

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Spastic hemiplegia

Senility (duration) Unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

6-27-19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Nat'l Date of Burial 7/ 1927

20 UNDERTAKER [illegible] ADDRESS 121 Virginia Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

E 23552

CERTIFICATE OF DEATH.

E 23552

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 Aisquith St., Hebrew Aged Home St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Sindler

(a) RESIDENCE NO. 115 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Sindler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Yetta Sindler

(Address) 1127 E Balto. St.

Filed ..... 19 ..... Registrar

JUL 1 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidently fell from 3rd story window-at 115 Aisquith St

Broken neck (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

Signed J. J. Kelly, M. D. (Coroner)

6/30/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Rosedale	7/1 1927
20 UNDERTAKER Sol Heinsohn & Bro	ADDRESS 1127 E Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 23553

1-PLACE OF DEATH

REGISTERED NO. E 23553

City of BALTIMORE: (No. 834 Warner St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Finney

(a) RESIDENCE NO. 834 Warner St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Finney

6 DATE OF BIRTH (month, day, and year) ——— 18??

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swindells

9 BIRTHPLACE (city or town) Warren Co

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Jane Finney

13 BIRTHPLACE OF MOTHER (city or town) Warren Co

(State or country) Virginia

14 Informant Birdella Hawkins

(Address) 834 Warner St

Filed JUL 1 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29 1927

17 I HEREBY CERTIFY, That I attended deceased from May 29 1927, to 6/29 1927, that I last saw him alive on 6/28 1927, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis +

Nephritis (duration) yrs. mos. (Chronic) ds.

18 Where was disease contracted if not at place of death*

Did an operation precede death* No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dan'l Cruchen M. D.

6/29 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Auburn July 1 1927

20 UNDERTAKER — ADDRESS 1027

John H. Toadvine Round Hill

Fill in above accurately supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Merkin

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 23554

E 23554

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO.

City of BALTIMORE: (No. Caroline & Eager St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs susie merkin

(a) RESIDENCE NO. 815 w fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: geo merkin

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 33 Months Days IF LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Russia

14 Informant: Geo Merkin (Address): 815 W Fayette St

15 Filed JUL 1 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/26/27 19 to 6/28/27 19 27

that I last saw h alive on 6/28/27 1927

and that death occurred on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Uremic cellulitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos 2 days

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? yes Date of 6/26/27

Was there an autopsy? yes Hospital

What test confirmed diagnosis? Clinical

(Signed) H. R. McCall, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ly Redeemer — Date of Burial 6/25/27

20 UNDERTAKER: Charles H. Tuchausen — ADDRESS

NOTE—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23555 (1-PLACE OF DEATH)

118-002

E 23555 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No.) Church Home Hospital St., Ward)

2-FULL NAME Emma Valentine

(a) RESIDENCE NO. 728 East 36th St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Valentine

6 DATE OF BIRTH (month, day, and year): Nov 28. 1878

7 AGE: Years 48 | Months 7 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Adolph Bulgemeister

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mehnert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Henry Valentine

(Address) 728 E. 36th St.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 30, 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3 1927, to June 30, 1927, that I last saw h[illegible] alive on June 30, 1927 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

from adhesions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia & Chronic intestinal obstruction - Gallstones

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/24/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Mercedes L. Tolson M. D.

, 19 (Address) Church Home Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial: July 4 1927

20 UNDERTAKER: Wm. Cook ADDRESS: 502 E. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 23556

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 E 23556

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (St. 96-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Laing

(a) RESIDENCE NO. 3305 Myrtle Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Laing

6 DATE OF BIRTH (month, day, and year) Apr 12 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	52	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 60

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Laing

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Ellierthorpe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Hospital Records

(Address)

15 Filed JUL 1 1927 19 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 27, to June 30, 19 27,

that I last saw h im alive on June 30, 19 27,

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Gatchell, M. D.

6-30 1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

Date of Burial July 2 1927

20 UNDERTAKER W. A. Cook

ADDRESS 502 E Lafayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23557 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 23557

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 521 N. Schroeder St. 18-26 WARD)

2-FULL NAME Rev. John E. Dunn

(a) RESIDENCE NO. 521 N. Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? 71 yrs. 8 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
71		8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergy - R.C. Priest

(b) General nature of Industry, business, or establishment in which employed (or employer) R.C.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Long Green Balto Co Md

PARENTS

10 NAME OF FATHER Michael O'Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Joseph Dunn

(Address) 3927 Edmondson Ave

15 Filed JUL 1 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1927, to 6/28, 1927.

that I last saw him alive on 6/28, 1927.

and that death occurred, on the date stated above, at 9.9. m.

The CAUSE OF DEATH* was as follows:

Monocytosis anemia

Chronic Endocarditis & Chronic Interstitial nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. examination

(Signed) John T. Dunn, M. D.

4/30, 1927 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7-1-1927

20 UNDERTAKER Henry C Branning for

ADDRESS 517 N. Schroeder St

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23558

90 E 23558

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Holliday & Pleasant Sts. St. 26-11 Ward)

2-FULL NAME George E. McClean.

(a) RESIDENCE NO. 680 N. Highland Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state CAUSE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXX HUSBAND of XXXXXXXXX Margaret A. McClean.

6 DATE OF BIRTH (month, day, and year) May 17 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern maker.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph McClean.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah Martin.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Baltimore, Md.

14 Informant Margaret A. McClean. (wife)

(Address) 680 N. Highland Ave.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D.

(Coroner)

7/1 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery Date of Burial July 5 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager St.

Cor.—12-9-25—A Co.—200 Bks.

E 23559

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

CERTIFICATE OF DEATH.

E 23559

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St. 6-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander White

(a) RESIDENCE NO. 125 N. Duncan St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Elizabeth White

6 DATE OF BIRTH (month, day, and year) March, 4th. 1836

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	91	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Eastern Shore Md.

PARENTS

10 NAME OF FATHER ------ White

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Eastern Shore Md.

12 MAIDEN NAME OF MOTHER Caroline-----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Eastern Shore Md,

14 Informant Mrs. Elsie Elizabeth White

(Address) 125 N. Duncan St.

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intrathoracic & abdominal injuries accidently run over by automobile Fayette & Chester Sts.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Inquest 6/30/27

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Collins M. D.

(Coroner)

6/30/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial 6/31/27

20 UNDERTAKER Philips Herwig ADDRESS 2016 Orleans St.

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

188 E 23560

E 23560

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 15-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert F.H.Bell.(C)

(a) RESIDENCE NO. 1382 N.Calhoun St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 27, 1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News dealer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER William M.Bell (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Annie Austin.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Helen Paull.(C) sister.

(Address) 1382 N.Calhoun St.

Filed JUL 1 - 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the hip. Hemorrhage. Shock.
Struck and crushed against a light pole.
by an automobile truck.
Accidental Death.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

(Signed) Otto Reinhardt (Coroner)

6/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? St. Paul & Lexington Sts. June 27, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlottesville, Va. Date of Burial July 2 1927

20 UNDERTAKER George I. A. Gibson ADDRESS 1735 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 23561

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 23561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3004 Hilton St (St.) 15-61 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius F. Sachs

(a) RESIDENCE NO. 3004 Hilton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Sachs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Levinson

(Address) 3004 Hilton St

C. HAMILTON JONES, M. D.

15 Filed July 1 1927 by [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 1927, to 7/1, 1927, that I last saw h[illegible] alive on 6/30 1927 and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) C Hamilton Jones, M. D.

7/1, 1927 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern	July 1 27
20 UNDERTAKER	ADDRESS
Jack Levis 1439	E Balt St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23562

CERTIFICATE OF DEATH.

44 E 23562

28-63

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4108 Groveland St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie E Powers

(a) RESIDENCE NO. 4108 Groveland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mervin M Powers

6 DATE OF BIRTH (month, day, and year) Sept 25 76

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Jesse F Billmyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jambert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mervin M Powers

(Address) 4108 Groveland

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

JUL 1 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

June 29

17 I HEREBY CERTIFY, That I attended deceased from June 25 19..., to June 29 19...,

that I last saw h.. alive on June 29, 1927,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Bad Stomach

(duration) 9 yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial June 30 1927

20 UNDERTAKER W M Coulson ADDRESS 2234 N Mrtt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23563

CERTIFICATE OF DEATH.

145-007

E 23563

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lera Muse

(a) RESIDENCE NO. 1532 W Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55-	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) in the Co. by

(State or country) Balto.

PARENTS

10 NAME OF FATHER William J Holmes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va —

12 MAIDEN NAME OF MOTHER Trendy Holmes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs R A Elliott

(Address) 1725 Ashland Ave

15 Filed 1-2 1927 C. HAMPTON JONES M. D. Registrar

Par R A C

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia by Illuminating Gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

1-2, 19 27 (Address) 43 Hol Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Calvary Cemetery Jan 3 1927

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725 Ashland Ave

OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 23564

E 23564

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Saunders

(a) RESIDENCE NO. 1423 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Mitchell Saunders

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Richmond

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMILTON JONES, M. D.

JUL 1 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927 to June 29, 1927, that I last saw h. alive on June 28, 1927, and that death occurred, on the date stated above, at 11:25 A m.

The CAUSE OF DEATH* was as follows:

Meningitis - Tuberculous

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sab

(Signed) C. Hubbard Boyd M. D.

19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial 6/30 1927

20 UNDERTAKER Edward Jordan — ADDRESS Govanstown

IT IS IMPORTANT that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26 A 25-30M Blks.

E 23565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23565

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) 17-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sydney Aydlotte

(a) RESIDENCE NO. 516 W. Preston st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grant Aydlotte

6 DATE OF BIRTH (month, day, and year)
1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER ? Guestey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Hospital Records

(Address)

15 Filed JUL 1 - 1927 Registrar HAMILTON ROWLES, M. D.

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 27, to June 28, 19 27, that I last saw her alive on June 28, 19 27, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. E. Gallup, M. D.

6-29-27 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lubrey

Date of Burial 7/1 1927

20 UNDERTAKER Samuel P. Smedley

ADDRESS 518 N. Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Berry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23566 | E 23566

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. (or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Berry

(a) RESIDENCE NO. 1232 Ellwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (Write the word)
female	col -	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Berry

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER [illegible] Mabry

11 BIRTHPLACE OF FATHER (City or town) Va -

(State or country)

12 MAIDEN NAME OF MOTHER Lucinda

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant (Address) Mrs Geo Berry 617 Gold St

15 Filed ..... 19 ..... Registrar

JUL 1 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-5-27, 19..., to 6-29-27, 19..., that I last saw h[illegible] alive on 6-29-27, 19... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia, right lung
3 mos duration
Chr. myocarditis
Duration unknown

CONTRIBUTORY (Secondary) Bronchopneumonia.

mania (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? St Louis

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Dr Hopkins

(Signed) [illegible] M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial 7/2 1927

20 UNDERTAKER Samuel T Beverley ADDRESS 578 W Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-9-25 - 1-5-26 - 300 Bks.

E 23567

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23567

129

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 Robert St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Gregory

(a) RESIDENCE NO. 416 Robert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Carrie Gregory

6 DATE OF BIRTH (month, day, and year) Sept 3, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Carrie Gregory

(Address) 416 Robert St

15 Filed ..... 19 ..... C. HAMPSON JONES

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1925 to June 25, 1927, that I last saw him alive on June 11, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Was there an autopsy?

What test confirmed diagnosis? Autopsy exam

(Signed) E. Wilbourn Frey, M. D.

June 29 1927 (Address) 938 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial July 1 1927

20 UNDERTAKER Harry T. Hardesty ADDRESS 570 N. Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23568 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 23568

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1355 Homestead ST., 9-46 (WARD)

2-FULL NAME John Harmon Dietrich

(a) RESIDENCE NO. 1355 Homestead ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula S. Dietrich

6 DATE OF BIRTH (month, day, and year) July 24th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carriage Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 007

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lula S. Dietrich
(Address) 1355 Homestead St.

15 Filed JUL 1 1927 19 Per R K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from March 29. 1927. to June 30. 1927. that I last saw him alive on June 30. 1927. and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculosis of 3rd + 4th vertebra of Spine (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Sputum analysis

(Signed) R W Redo M. D.

7/1. 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL July 2nd 1927

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23569

CERTIFICATE OF DEATH.

1/129 E 23569
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 622 N. Mount St. St. 1627 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Pope [redacted]

(a) RESIDENCE NO. 622 N. Mount St. St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James [redacted] Pope

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE: Years 34 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): N.C. arolina

PARENTS

10 NAME OF FATHER: Amos Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country): N.C.

12 MAIDEN NAME OF MOTHER: Minnie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): N.C.

14 Informant: Almond L. Pope
(Address): 622 N. Mount St.

15 Filed JUL 1 1927 C. HAMPSON JONES, M. D. Registrar
by _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29th. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27th. 1927 to June 29th. 1927, that I last saw her alive on June 29th. 1927, and that death occurred, on the date stated above, at 11.05 A M

The CAUSE OF DEATH* was as follows:

Brooken compensation cardiac
(Mitral Ins.)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Dodson M. D.

19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roseboro N C

Date of Burial: July 1 1927

20 UNDERTAKER: Samuel Easton

ADDRESS: 916 Pa ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23570 129E 23570

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 713 S. Green St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Holmes

(a) RESIDENCE NO. 713 S Green St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or min
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 074

(b) General nature of industry, business, or establishment in which employed (or employer) (Sterefine)

(c) Name of employer American Sugar Ref. Dappahannock

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Edna Wheatley

(Address) 713 S. Green

15 Filed 6-29 1927 C. HAMPSON JONES, M.D. Registrar

Par, [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 28 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/13 1927 to 6/28 1927, that I last saw h alive on June, 28 1927, and that death occurred, on the date stated above, at 6:25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Uraemia & Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine ++

(Signed) Dan Francken M. D.

6/29 1927 (Address) 722 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemtery Date of Burial 7-2 1927

20 UNDERTAKER Walter B. Spriggs ADDRESS 139 W. Hamburg St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23571

E 23571

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St. 713 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mathe Brockmeyer

(a) RESIDENCE NO. 1901 E Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. da. How long in U. S. if of foreign birth? life yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Brockmeyer

6 DATE OF BIRTH (month, day, and year): June 15 1895

7 AGE: 32 Years — Months — Days 14 — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John Lind

11 BIRTHPLACE OF FATHER (City or town): South Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Lind

13 BIRTHPLACE OF MOTHER (city or town): South Md

(State or country)

14 Informant: John Brockmeyer

(Address) 1906 E. Chase St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By MRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/1927

17. I HEREBY CERTIFY, That I attended deceased from 6/20/27 19 27 to 6/29/27 19 27,

that I last saw h[er] alive on 6/29/27 19 27,

and that death occurred on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 19 ds.

CONTRIBUTORY Cardiac Dilitation

(Secondary)

(duration) yrs. mos. 1 Year

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 6/29/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H. H. McCarthy M. D.

19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial 7/1 1927

20 UNDERTAKER: George J Ruth — ADDRESS 1730 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23572

CERTIFICATE OF DEATH

90 E 23572

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [illegible] St., 22 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rem Jackson

(a) RESIDENCE NO. 810 Peach alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant M. D. City

(Address) Records C. HAMPSON JONES, M. D.

15 Filed 19

1927 Per 1506 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927 to June 29, 1927

that I last saw him alive on June 29, 1927

and that death occurred, on the date stated above, at 7.00 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chr. & acute

myocardial failure

(duration) yrs mos 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Sect.

(Signed) C. Holmes Boyd, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23573

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23573

CERTIFICATE OF DEATH

161-00

1-PLACE OF DEATH

City of BALTIMORE (No. 6445 S. 14th St. 26-37 Ward)

2-FULL NAME Baby Vurela

(a) RESIDENCE NO. 6445 14th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 28 27

7 AGE: Years | Months | Days: 1 | If LESS than 1 day.. hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John Vurela

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER: Anna Latrace

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Jamaica

14 Informant

(Address)

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

1503 24th

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29. 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 28 19 to June 29, 19 27,

that I last saw him alive on , 19 ,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Stomach Burst

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rzanek M. D.

(Address) 30 W. Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

JUL 1 - 1927

This certificate must be filled out in every case, as far as may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23574

E 23574

CERTIFICATE OF DEATH.

REGISTERED NO. 65

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3112 Abell Ave St., 17-50 WARD)

2-FULL NAME John E. Robertson

(a) RESIDENCE NO. 3112 Abell Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 27 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.....min.
	17	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred K. Wm Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edna A. Hamenwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Edna A. Robertson

(Address) 3112 Abell Ave

15 Filed ...1927... 19 C. HAMPSON JONES, M. D. Registrar

Per R R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept 4~~ 26 to June 30, 1927, that I last saw him alive on June 30, 1927, and that death occurred, on the date stated above, at 2.15 m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

Life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 320 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 2, 27

20 UNDERTAKER Wm Tucker Sons ADDRESS North St

Note—It is very important that the instructions on back of certificates be carefully observed.

Spec.–7-17-26—A Co.—200 Bks.

E 23575

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23575

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 W. West St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Edwards

(a) RESIDENCE NO. 528 W. West St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Edwards

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 58 — Months: — — Days: — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): A. A. County

(State or country): Maryland.

PARENTS

10 NAME OF FATHER: Prince Jessa

11 BIRTHPLACE OF FATHER (city or town): Calvert Co

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Sarah Gray

13 BIRTHPLACE OF MOTHER (city or town): Calvert Co

(State or country): Maryland.

14 Informant: Jamie Butler

(Address): 528 W West

15 Filed 1-1927 19 C. HAMPSON JONES, M. D. Registrar

Per R C H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/1 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/16, 1927, to 7/1, 1927, that I last saw her alive on 6/30, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Chr Nephritis + Arterio sclerosis (Chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + + +

(Signed) Dan Drummer M. D.

7/1, 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: July 4, 1927

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 322 N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

E 23576

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 23576

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1157 E Lombard St. 35 Ward)

2-FULL NAME Eva Sopinski

(a) RESIDENCE NO. 1157 E Lombard St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew Sopinski

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At work

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Andrew Sopinski

(Address) 1157 E Lombard St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) _____ yrs. one mos. _____ ds.

CONTRIBUTORY (Secondary) probably Uremia

abscess (duration) _____ yrs. _____ mos. _____ ds.

(Signed) James W Pendon M. D. (Coroner)

7-5, 1927 (Address) 7006 Clarendon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baetz Cem Date of Burial July 7 1927

20 UNDERTAKER Mc Fadyen & Co ADDRESS 1618 Eastern Ave

very important. See instructions on back of certificate.

be properly classified. Exact statement of OCCUPATION is

(Pine Crest Sanitorium, Ivorwood Ave.)
Residence - Cherry Hill, Westport

Spec.—1-10-21 M&T 1500 Bks.

E 23577

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23577

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pine Crest Sanitorium — REGISTERED NO. 75-32

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number) Pine Crest Sanitorium, Ivorwood Ave.

2-FULL NAME Mary A. Seaman

(a) RESIDENCE NO. Pine Crest ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Seaman

6 DATE OF BIRTH (month, day, and year) June 10th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lizzie M. Seaman
(Address) Cherry Hill Westport

15 Filed 1927 C. HAMPSON JONES, M. D. 1927
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1927, to 6/29, 1927, that I last saw h[illegible] alive on 6/28, 1927 and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia
(Contributory Contusion of Hip)
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion of Hip
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Kerr, M. D.

6/30 1927 (Address) 7 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 2 1927
20 UNDERTAKER	ADDRESS
E. Schlosman Son	1037 Hanover

TION is very important. See instructions on back of certificates. ...ccupa-

Spec.—1-10-21—M&T—1500 Blks.

E 23578 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23578

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Brookline Ave ST., 13-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hamilton Stone

(a) RESIDENCE NO. 3907 Brookline Ave ST.,

WARD Rustburg Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Bird Stone

6 DATE OF BIRTH (month, day, and year) June 21. 1860

7 AGE: Years 67; Months; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rustburg Va

PARENTS

10 NAME OF FATHER Joseph Hamilton Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy A. Cobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs H. A. Stewart

(Address) 3907 Brookline Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to June 30 1927.

that I last saw h[illegible] alive on June 30 1927.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) about yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Paralysis Agitans

from history (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S Riblett M. D.

1927 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rustburg Va

DATE OF BURIAL July 2 1927

20 UNDERTAKER Jos Jordens + Son

ADDRESS 217 S Paca St

TION is very important. See instructions on back of certificates. EXACT statement of OCCUPA-

Spec.-7-17-26—A Co.—200 Bks.

E 23579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129E 23579

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 E Layfette ave 4-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. H. O'Niel

(a) RESIDENCE NO. 1311. E Layfette ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S. if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late May. E. O'Niel

6 DATE OF BIRTH (month, day, and year): Feb 19 1845

7 AGE: Years 82 Months 4 Days 10

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: John. O'Niel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: May. E. O'Niel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Nellie. O'Niel

(Address) 1311. E Layfette ave.

15 Filed JUL 1 1927

C. HAMPSON JONES, M. D. Registrar

By ——

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to June 29, 1927, that I last saw him alive on June 29, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 5 (?) yrs. mos. ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jno. R. Geraghty, M. D.

July 1927 (Address) 2225 St. Paul St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

Date of Burial: July. 4 1927

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford ave.

Please answer in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Zimmerman 2565 Hopk. Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23580

CERTIFICATE OF DEATH.

129 E 23580

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Holbrook St. 9-16 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter K. Resh

(a) RESIDENCE NO. 1606 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) March 12 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Penn. R R.

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER John Resh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sara Krall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Resh

(Address) 1606 Holbrook

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

1927 Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1927, to June 30, 1927.

that I last saw him alive on June 30, 1927.

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo F. Zimmerman M. D.

7/1, 1927 (Address) 2868 Hampden Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL July 4 1927

20 UNDERTAKER Wm Cook — ADDRESS 501 E N. Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23581

CERTIFICATE OF DEATH.

179 E 23581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Webster ST., 24th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clayton Bryant

(a) RESIDENCE No. 1718 Webster ST., 24th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Melvin Bryant.

6 DATE OF BIRTH (month, day, and year) Nov 18, 1853 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Co, Virginia.

PARENTS

10 NAME OF FATHER ..... Elmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Virginia Mullen (Address) 1044 Patapsco St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1927 to July 1, 1927.

that I last saw her alive on June 30, 1927.

and that death occurred, on the date stated above, at 11 50 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 4 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E Lafayette

TIONS is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23582

CERTIFICATE OF DEATH

11-006 E 23582

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 606 Fair Oaks Ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Leona Connell

(a) RESIDENCE NO. 606 Fair Oaks Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11th 1927

7 AGE: Years 0 Months 6 Days 20

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Charles S. Connell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Evelyn Ackbern

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs Charles S. Connell mother

(Address) 606 Fair Oaks Ave

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

7-1-1927 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from June 26 1927 to July 1st 1927

that I last saw her alive on July 1st 1927

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. K. Gordy M. D.

7-1 1927 (Address) 718 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial July 2 1927

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23583

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

E 23583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 313 S. Bond St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Gorthier

(a) RESIDENCE NO. 313 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Gorthier

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at home 039

(c) Name of employer

9 BIRTHPLACE (city or town): Washington

(State or country): D C

PARENTS

10 NAME OF FATHER: Addison

11 BIRTHPLACE OF FATHER (city or town)

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unknown

14 Informant: Charles Gorthier

(Address): 313 S Bond

15 Filed: 1927 by C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) June 30 1927

thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to (her) death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Alcoholism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James H. Taylor M. D. (Coroner)

6/30 1927 (Address) 706 Chanel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem. Date of Burial: July 2. 1927.

20 UNDERTAKER: Wendell & Lippel ADDRESS: 500 S Eden.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

E 23584

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23584

CERTIFICATE OF DEATH

176

1-PLACE OF DEATH

REGISTERED NO. 25-37

City of BALTIMORE: (No. Balto City Hospital St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Pitchard

(a) RESIDENCE NO. 6175 2nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 22. 1902

7 AGE: 25 Years Months Days. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Pitchard

11 BIRTHPLACE OF FATHER (City or town): Baltimore Md

(State or country):

12 MAIDEN NAME OF MOTHER: Mrs Kurrie

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country):

14 Informant: George Hannagan

(Address) 3 E S. Eutaw St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-30-27

17 I HEREBY CERTIFY, That I attended deceased from 6-13- 1927 to 6-30- 1927

that I last saw him alive on 6-30- 1927

and that death occurred, on the date stated above, at 10.00 p.m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Nephritis

Hypertension - Generalized

Peritonitis (Pneumococcic) -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6-30-27

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — Date of Burial: July 3 1927

20 UNDERTAKER: Wendell J. Lippel — ADDRESS: 301 S. Edmondson

Be careful to print plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23585

CERTIFICATE OF DEATH

90 E 23585

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS, St., 4-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Williams.

(a) RESIDENCE NO. 926 W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1861

7 AGE: Years 66 Months 5 Days 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Yard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Anderson Williams

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address)

15 Filed 6-2-1927 C. HAMPSON JONES, M.D. Registrar

Per Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/1927.

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1926, to June 30, 1927, that I last saw h. alive on June 30, 1927 and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

My dear doctor, on
Cirrhosis Liver's
Hypertension

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Exam.

(Signed) C. Holmes Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. Date of Burial: July 2 19 27

20 UNDERTAKER: Samuel Steinberg ADDRESS: 1128 E Baltimore

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 E 23586

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 17 Belvidere Ave ST. 7-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Dorzen

(a) RESIDENCE NO. 17 Belvedere Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jacob Dorzen

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: Rev Thos R Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr Jacob Dorzen

(Address): 17 Belvedere Ave

15 Filed: 7-1927 19 Reg. NKB Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to June 30 1927

that I last saw h[illegible] alive on June 30 1927

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Pulmonary Oedema

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Chron Int Nep. Sclerosis of Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Theron Flatly, M. D.

7/1, 1927 (Address) 4 Donnell Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: 7/2/27

20 UNDERTAKER: Harry Hutzler 15 31 W

ADDRESS: Lombard St

Spec—12-23-21—E.B.R.S.—400 Eks.

E 23587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23587

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 So. Garrison Lane Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Richter

(a) Residence No. 17 So. Garrison Lane Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of ~~Late~~ Anna E. Richter

6-DATE OF BIRTH (month, day and year) Sept 27 1861

7-AGE. 65 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Coal cleaner

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. (State or Country) Md.

PARENTS.

10-NAME OF FATHER James Richter

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12-MAIDEN NAME OF MOTHER Elizabeth Zeigler

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country) Md.

14-

(Informant) Mrs. Anna E. Hawkins

(Address) 17 So. Garrison Lane

15-

Filed 192

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 30, 1927

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1927, to June 30 1927

that I last saw him alive on June 29 1927

and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate & bladder.

(Duration) yrs. 2 mos. 1 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leonard E Byrd M. D.

6/30/27 19 (Address) 2229 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: 7/4/27 19

20-UNDERTAKER: Harry A Wiltse ADDRESS 100 Eutaw

1927 C. HAMPSON JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23588 ✓ E 23588

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Kenwood Ave ST.) 6 10 (WARD)

2-FULL NAME Ella V. Hanley

(a) RESIDENCE NO. 132 N Kenwood Ave ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred — 9 mos. — How long in U. S., if of foreign birth? 63 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS ✓

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Hanley

6 DATE OF BIRTH (month, day, and year) Jan 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 37

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George W. Hanley (Address) 132 N. Kenwood Ave

15 Filed 7-2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22 1926 to July 1, 1927.

that I last saw her alive on July 1, 1927.

and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Aortic Regurgitation

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert Klingenfeld M. D.

7/1/1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 7/4 1927

20 UNDERTAKER Louis Heemann — ADDRESS 3rd & Biway

INSTRUCTIONS: Use typewriter or indelible pencil. See instructions on back of certificates. PENALTY FOR MAKING FALSE STATEMENT OR OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23589 ✓ 90 E 23589

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 Bloomberg St. 24-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Blake

(a) RESIDENCE NO. 110 Bloomberg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Blake

6 DATE OF BIRTH (month, day, and year): Aug 8 1892

7 AGE: Years 34 Months 10 Days 23

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Brooklyn N.Y.

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Rehm

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Matilda Schmaltzlaugh

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Matilda Rehm

(Address) 632 Clarkson St

15 Filed 7-2-1927 C. HAMPSON JONES, M. D. Registrar

Per BFA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to July 1 1927

that I last saw h alive on July 1 1927

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. H. Campbell M. D.

19 27 (Address) 1544 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park July 4 1927

20 UNDERTAKER: A. H. Kraus Estate ADDRESS 88 E. Fort Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23590 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23590

56

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2550 Mace St ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Woolford

(a) RESIDENCE NO. 2550 Mace St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Bells Bay (State or country)

PARENTS

10 NAME OF FATHER John Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lena Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lena Woolford

(Address) 2550 Mace St.

15 Filed 2-1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924 to July 1, 1927, that I last saw her alive on June 30, 1927 and that death occurred, on the date stated above, at 12 00 P. M.

The CAUSE OF DEATH* was as follows:

Rickets, Marasmus and Intussusception Mal nutrition

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Rickets Genu of Coxa (duration) ? yrs ? mos. ? ds.

18 Where was disease contracted if not at place of death? Cumberland

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical

(Signed) Chas. S. Ritchie, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL July 2 1927

20 UNDERTAKER Daniel Easton

ADDRESS 916 E 20th St

Spec.—1-10-21—M&T—1500 Blks.

E 23591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23591

CERTIFICATE OF DEATH.

62

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3216 Elmley Ave ST. 8-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J Fitzsimmons. 3rd

(a) RESIDENCE NO. 3216 Elmley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 22, 1927

7 AGE — Years: ✓ — Months: 2 — Days: 9 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant old

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Thomas J Fitzsimmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER Mary D Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs Thomas J Fitzsimmons

(Address) 3216 Elmley Ave.

15 Filed July 2 1927 C. HAMPSON JONES, M. D. Registrar

By P.P.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1927, to July 1, 1927, that I last saw him alive on July 1, 1927, and that death occurred, on the date stated above, at 8 35 P m.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus

(Status Thymicolymphaticus)

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray.

(Signed) John A Baldwin, M. D.

July 1, 1927 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 3 1927

20 UNDERTAKER: Henry Hoen & Son — ADDRESS: 1201 E Eag. St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23592

CERTIFICATE OF DEATH.

90 E 23592

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2804. Simpson St., 9-46 Ward)

2-FULL NAME Rosa Richard.

(a) RESIDENCE NO. 2804. Simpson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5- yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 Color or Race: col

5. Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Garnett Richard

6 DATE OF BIRTH (month, day, and year): Unknown 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Elberton Ga.

9 BIRTHPLACE (city or town): (State or country)

PARENTS

10 NAME OF FATHER: Byrd Fabius

11 BIRTHPLACE OF FATHER (city or town): (State or country) Elberton, Ga.

12 MAIDEN NAME OF MOTHER: Mary Gains

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Elberton, Ga.

14 Informant: Garnett Richard

(Address) 2804 Simpson St

15 Filed ..... 19 ..... Registrar

1921 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 1,

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to July 1, 1927, that I last saw h... alive on July 1, 1927 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Vanular Heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) C. A. Johnson, M. D.

, 19 (Address) 2329 Gwynn Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial July 5 1927

20 UNDERTAKER: Mrs R. G. Elliott ADDRESS 1725 Ashland Ave

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 23593

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23593

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N. Mount St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Griffin

(a) RESIDENCE, No. 1004 N. Mount St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife~~ of: Mary Griffin

6 DATE OF BIRTH (month, day, and year): Jan. 26, 1866

7 AGE — Years: 61 — Months: 5 — Days: 3 — If LESS than 1 day, hrs. or min.: 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jerry Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): Mary Griffin 1004 N. Mount St.

15 Filed 6/30, 1927 — C. HAMPSON JONES, M. D. Registrar. Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1926 to June 29, 1927.

that I last saw him alive on June 29, 1927.

and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) 1 yrs. 4 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.

(Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 3 1927
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	225 Ashland Ave.

Give instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23594

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23594

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 32

City of BALTIMORE: (No. 33rd & Calvert St.) 26-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Anna Rohlfing

(a) RESIDENCE NO. 27 E. Spring Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10, 1927

7 AGE: Years — Months 3 — Days 20

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt.

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Rohlfing

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anna Nies

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mother

(Address) 27 E. Spring Ave.

15 Filed ... 19... C. HAMPSON JONES, M. D.

1927 Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to July 1, 1927, that I last saw her alive on July 1, 1927, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Diagnosis not made. Possible Tuberculous Meningitis. Cut not proven

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Home

(Signed) James Arthur Lemley, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: July 4 1927

20 UNDERTAKER: George W. Zirkle — ADDRESS: 1737 E. Eager St.

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 23595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 23595

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1713 Westwood Ave (Ward) 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Lee Cromer

(a) RESIDENCE. (No.) 1713 Westwood Ave. (Ward)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28, 1909

7 AGE — Years: 17 — Months: 11 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Concord North Carolina

PARENTS

10 NAME OF FATHER: Henry Cromer

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Julia Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Concord North Carolina

14 Informant (Address): Mrs Julia Cromer 1713 Westwood Ave

15 Filed 2-1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29-1927

17 I HEREBY CERTIFY, That I attended deceased from 6-21-, 1927 to 6-29, 1927, that I last saw h.. alive on 6-29, 1927, and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary tuberculosis

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted If not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John C. F. Clampett M. D.

, 19 (Address) 1400 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: July 2 1927

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pierstmon

This is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Bks.

E 23596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23596

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Green ST. 22-30 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Viola Steward

(a) RESIDENCE NO. 716 Green ST., 22 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26-1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	32	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Steward

11 BIRTHPLACE OF FATHER (city or town) Newburn (State or country) N. C.

12 MAIDEN NAME OF MOTHER Georgiana Young

13 BIRTHPLACE OF MOTHER (city or town) Baltod (State or country) Md.

14 Informant William H. Steward
(Address) 601 St Charles ave

15 Filed ..... 19 C. HAMPSON JONES, M. D.
1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/1927

17 I HEREBY CERTIFY, That I attended deceased from 5/24/, 1927, to 7/1/, 1927, that I last saw her alive on 7/1/, 1927, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation; Pulmonary Edema, Anasarca.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia Septicemia (duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & History

(Signed) J. M. Bishop, M. D.

, 19 (Address) 707 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct — DATE OF BURIAL July 3 1927

20 UNDERTAKER L. L. Brown & Son — ADDRESS 1016 W. Mond

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23597

CERTIFICATE OF DEATH

47 E 23597

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 Gen Hosp St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ella McCullough

(a) RESIDENCE NO. 1211 Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 If Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 4-21-1863

7 AGE: Years 64 Months (2) Days (9) IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Chas F McCullough

11 BIRTHPLACE OF FATHER (City or town): Phila

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Hannah Kane

13 BIRTHPLACE OF MOTHER (city or town): Phila

(State or country): Pa

14 Informant (Address): Hospt Records

15 Filed 7-2-1927 C. HARRISON JONES, M. D. Registrar

Per RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-30-27

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1927, to June 30th, 1927,

that I last saw h[illegible] alive on June 30, 1927,

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Malignant Carcinoma of the breast & metastasis to liver & bones & Intestinal Obstruction

(duration) ? yrs. mos. ds. noted 1 yr ago

CONTRIBUTORY Senility & Arteriosclerosis

(Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No Why? Clinical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery Date of Burial July 4 1927

20 UNDERTAKER: John B Spence ADDRESS 1328 N Caroline

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23598

185 E 23598

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute to

City of BALTIMORE: (No. Hopkins Hospital St. 2-4 Ward)

2-FULL NAME Catina Cortesis

(a) RESIDENCE NO. 1620 Aliceanna St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or..... min.
X	—	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Leonidas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) greece

12 MAIDEN NAME OF MOTHER Ourania

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) greece

14 Informant Rev Phil Sebastrades

(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage (secondary)

Accidently fell out of bed six weeks ago.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hollan M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the state..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial 7/2 1927

20 UNDERTAKER Wm Cook ADDRESS 502 Druid Hill Ave

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23599

E 23599

CERTIFICATE OF DEATH. 1927

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 30 Ward)

2-FULL NAME Mary E. Bohm

(a) RESIDENCE NO. Essex Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE: Years 18 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Con. Can

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. L. Bohm

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Brady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Hos. Records

(Address) Univ. Hospital

15 Filed..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 30 1927

17 I HEREBY CERTIFY that I have viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

June 29 1927 (Signed) G. C. Yates M. D. (Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.... yrs.. mos.. ds. In the state.... yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. Date of Burial: 7/2 1927

20 UNDERTAKER: John G. Connelly ADDRESS: Essex Md.

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23600 | CERTIFICATE OF DEATH | 185 E 23600

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1115 Greenmount Ave St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Herring

(a) RESIDENCE NO. Finksburg St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 Dy. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Wh.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joshua Herring

6 DATE OF BIRTH (month, day, and year): 12-7-1842

7 AGE: Years 82 Months 6 Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Finksburg

(State or country): Md

PARENTS

10 NAME OF FATHER: Jno Armacost

11 BIRTHPLACE OF FATHER (City or town): Finksburg

(State or country): Md

12 MAIDEN NAME OF MOTHER: Barbara Lessner

13 BIRTHPLACE OF MOTHER (city or town): Finksburg

(State or country): Md

14 Informant

(Address): Hospital Records

15 Filed JUL 3 - 1927, 19

Registrar

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7-2-27

17 I HEREBY CERTIFY, That I attended deceased from 6-20-27, 19, to 7-2-27 19

that I last saw h alive on 7-2-27, 19

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Fracture Kneecap (Acc.)

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) A Diff Temperature

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Compston, M. D.

, 19 (Address) 1115 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — Date of Burial: July 4 1927

20 UNDERTAKER: W M Royston — ADDRESS: 2208 N Mott.

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23601

CERTIFICATE OF DEATH

101-001

E 23601

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen. Hosp. St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss ELIZABETH Bear

(a) RESIDENCE NO. 3715 Old York Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 25, 1852

7 AGE	Years	Months	Days
	75	5	6

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Smithsburg

(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Bear

11 BIRTHPLACE OF FATHER (City or town) Smithsburg

(State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Kendig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Hospital Record

(Address)

15 Filed (, 19) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7 1 27

17 I HEREBY CERTIFY, That I attended deceased from 6-28, 1927, to 7-1, 1927, that I last saw her alive on 7-1, 1927, and that death occurred, on the date stated above, at 8 50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

1

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Strong, M. D.

, 19 (Address) The Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro Pa. Date of Burial July 2 1927

20 UNDERTAKER Richard F. Cuskey ADDRESS 2066 York Rd

JUL 5 1927 HAMPDEN-WOODBERRY

RK.

E

very important. See instructions on back of certificates.

Exact statement of OCCUPATION is

be properly classified. Exact statement of CAUSE

Cor.—12-9-25—A Co.—200 Bks.

Young.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23602

CERTIFICATE OF DEATH.

128

E 23602

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 S Bethel St. 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella Young

(a) RESIDENCE NO. 209 S. Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ulysses Young

6 DATE OF BIRTH (month, day, and year) Dec 17 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) In family

(c) Name of employer

9 BIRTHPLACE (city or town) Salt City

(State or country)

PARENTS

10 NAME OF FATHER David Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Salt City

12 MAIDEN NAME OF MOTHER Eliza Johns

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St Michaels md

14 Informant Melvin Golden

(Address) 232 S Bethel St

15 Filed ....., 19.....

C. HAMPSON JONES M.D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Parenchymatous Nephritis

(duration) .....yrs. .....mos. 6 hrs ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) James H. Faulkner M. D.
(Coroner)

7/1, 1927 (Address) 7002 Chanst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany cemetery Date of Burial July 4 1927

20 UNDERTAKER Edward Bryan ADDRESS 163 orleans

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23603

CERTIFICATE OF DEATH.

+ 84

REGISTERED No. E 23603

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence R. Kepner.

(a) RESIDENCE NO. 5542 Jackson St, Pittsburgh, Pa. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

5a If married, XXXXXXXXXXXX HUSBAND of (XXXXXXXX Sarah Kepner.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Bison Oil Prod. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Cleveland Ohio.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Mrs. Earl Harvey.

(Address) 137 Cold Spring Ave.

15 Filed 7-3-1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner)

7/2, 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Hotel Caswell. June 30, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland, O. via Penn Ry. Date of Burial July 2 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-002

E 23604

CERTIFICATE OF DEATH.

E 23604

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Wilder

(a) RESIDENCE NO. 1064 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	2	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Victor Wilder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Wilder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Victor Wilder

(Address) 1064 Argyle ave

15 Filed ..... 19 .....

By ..... Registrar

C. HAMPSON JONES, M. D.

3 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 1, 1927, that I last saw him alive on July 1, 1927, and that death occurred, on the date stated above, at 9 25 p m

The CAUSE OF DEATH* was as follows:

Tons. & Laryngeal Diphtheria

from History

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated 7/1/27 (Date of)

Was there an autopsy? No

What test confirmed diagnosis Clinical-Bac. Culture

(Signed) Myron S. Tuck M. D.

7/2, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 7/3 1927

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Baltimore st

HOW IS very important See instructions on back of certificates. STATEMENT OF OCCUPA-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23605

CERTIFICATE OF DEATH.

E 23605

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Ward 21-29 St. ____ Ward)

2-FULL NAME Louisa Greenwald

(a) RESIDENCE NO. 1111 Ward St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jacob Greenwald

6 DATE OF BIRTH (month, day, and year): Aug 8 1850

7 AGE: Years 76 Months 10 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Jacob Greenwald

(Address): 1111 Ward St

15 Filed July 29 1927 [illegible] Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Coroner's autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 hr. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

July 29 1927 Signed: Thos. B. Horton M. D. (Coroner)

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial: July 5 1927

20 UNDERTAKER: John J. Lowry & Son ADDRESS: 501 Hollins St.

Use typewriter if possible. See instructions on back of certificate. Insert statement of OCCUPATION in

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23606

CERTIFICATE OF DEATH.

90 E 23606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 540 Brunswick St. (Ward) 20th

REGISTERED NO. 2049

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Haney

(a) RESIDENCE No. 540 Brunswick St., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah C. Haney

6 DATE OF BIRTH (month, day, and year) Feb 4-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer) A. Klein & Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John C Haney

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) New York

14 Informant John C. Haney

(Address) 540 Brunswick St

15 Filed Aug 8 1927 C. HAMPTON JONES, M. D. Registrar RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1926, to July 1, 1927.

that I last saw h— alive on June 30 1927.

and that death occurred, on the date stated above, at 9th a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 9 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James R Hazenbergen M.D.

7/2, 1927 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL July 4th 1927

20 UNDERTAKER F. D. Wagner — ADDRESS 1050 N Gilmor St

Spec.—1-12-23—M&T—500 Bks.

Feuchtner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23607 — 46 E 23607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2607 W Fairmount Ave (St.) West (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Feuchtner

(a) RESIDENCE NO. 2607 W Fairmount Ave ST. 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edmund Feuchtner

6 DATE OF BIRTH (month, day, and year): Oct 19th 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: P. Schleck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Pauline Stromeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Ferdinand Feuchtner (Address) 2607 W Fairmount Ave

15 Filed ..... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to July 1st 1927, that I last saw h[illegible] alive on July 1st 1927 and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Biopsy

(Signed) Chas W Kerfoot M. D.

(Address) 2105 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 4th 1927

20 UNDERTAKER: F. B. Hesselbrock, 1857 W. Baltimore St — ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23608

CERTIFICATE OF DEATH.

16 E 23608

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 N Arch St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Slater

(a) RESIDENCE NO. 109 N Arch St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓		—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Slater

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Pauline Chapman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Harry Slater

(Address) 109 N Arch St

15 Filed 3-1927, 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July - 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Air Embolism

(Duration) 1 yrs. mos. / ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

July 27, 1927 (Signed) H. C. Jones M. D. (Coroner)

(Address) 14 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lion — Date of Burial 9-3 1927

20 UNDERTAKER Joseph A Lively — ADDRESS 409 N Mount St

Use instructions on back of certificate. See important statement of OCCUPATION in

Spec.—1-10-21—M&T—1500 Bks.

E 23609

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23609

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 638 W. Barre ST., 17 WARD)

2-FULL NAME Benjamin Ayers

(a) RESIDENCE NO. 638 W. Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Ayers

6 DATE OF BIRTH (month, day, and year): [illegible] 1859

7 AGE: Years 68 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

074

9 BIRTHPLACE (city or town) (State or country): Accomac Co Virginia

PARENTS

10 NAME OF FATHER: James Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hannah Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mary Jubilee 638 W. Barre St.

15 Filed JY 1927 19 Registrar R/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1927

17

I HEREBY CERTIFY, That I attended deceased from June 10 1927 to June 30 1927.

that I last saw him alive on June 30 1927.

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs mos 21 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs mos. 27 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles H. Hines, M.D.

1927 (Address) 728 Pine St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harborton Whf

DATE OF BURIAL: July 3 1927

20 UNDERTAKER: Accomac Co

ADDRESS: 1027 Druid Hill

John H. Toadvine

GIVE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 23610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 23610

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 Rutland Av St., 8-17 Ward)

2-FULL NAME Wm C. Feige

(a) Residence No. 1801 Rutland Av St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ada Feige

6-DATE OF BIRTH (month, day and year) Aug 15/65

7-AGE. 61 yrs. 10 mos. 15 ds. Or LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Supt

(b) General nature of industry, business, or establishment in which employed (or employer) Umbrella Factory

(c) Name of employer Dang Bros

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Carl P. Feige

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Charlotte

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Carl W. Feige

(Address) 1801 Rutland Av

15-

Filed JUL 3 1927, 192.

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1/27

17- I HEREBY CERTIFY, That I attended deceased from Nov 6, 1926 to June 1, 1927 that I last saw h.. alive on June 1, 1927 and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 or 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, Bronchitis & Emphysema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) Hubert Thompson M. D.

July 2, 1927 (Address) 1216 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltolem — DATE OF BURIAL, July 4, 1927

20-UNDERTAKER Philip Henrig — ADDRESS 2016 Orleans St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23611

CERTIFICATE OF DEATH.

100-001

E 23611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 N Madison St., 11th Ward)

2-FULL NAME Georgie King

(a) RESIDENCE NO. 1108 N Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Louis King

6 DATE OF BIRTH (month, day, and year): July 14, 1907

7 AGE: 20 Years 11 Months 3 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Hall

11 BIRTHPLACE OF FATHER (city or town)

(State or country): md

12 MAIDEN NAME OF MOTHER: Maggie Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): md

14 Informant: Maggie Hall

(Address): 1100 Madison ave

15 Filed July 8, 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

July 8, 1927 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial July 8 1927

20 UNDERTAKER: Dennis Eastern ADDRESS 916 Bond

Fill out all questions. See instructions on back of certificate. If OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

Dr Damarco 1604 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23612 — CERTIFICATE OF DEATH. — E 23612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 14 Inglewood Ave (St.) (Ward) 43

REGISTERED NO. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Trecaricki

(a) RESIDENCE NO. 14 Inglewood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angelina Trecaricki

6 DATE OF BIRTH (month, day, and year) July 19 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Olgiro Trecaricki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Pardo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Interment Gambit Barsotti

(Address) 11 Inglewood Ave

15 Filed JUL 3 - 1927 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-27, 1927, to 6-30, 1927, that I last saw h alive on 6-30, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative gangrenous stomatitis - osteitis of superior maxilla.

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Myocarditis, general sepsis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-23-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) S. Damarco, M. D.

7-1 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 4 1927

20 UNDERTAKER W. H. Cook — ADDRESS 502 E Northern

Spec.–7-17-26—A Co.—200 Bks.

E 23613. HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 23613.

CERTIFICATE OF DEATH

Mount Pleasant

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1136 8th St. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Murray

(a) RESIDENCE NO. 1136 8th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred about 6 years How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Murray

6 DATE OF BIRTH (month, day, and year) Feby 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Owen Mulligan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mulligan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Annie Miller

(Address) 1136 8th St

15 Filed 7-3-1927, 19 C. HAMPSON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 27 to July 1, 19 27

that I last saw her alive on June 27, 19 27

and that death occurred, on the date stated above, at 12-10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. L. McClafferty M. D.

July 3 19 27 (Address) 1520 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial July 4 1927

20 UNDERTAKER Margaret J. Flynn ADDRESS Mt. Royal Ave

Exact statement of OCCUPATION is necessary and important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23614

CERTIFICATE OF DEATH

90

E 23614

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Abraham Schiff

(a) RESIDENCE NO. Eglinton Court apt E Town Place & Park Lane Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1852

7 AGE: Years 74 Months 11 Days 0

If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Was~~ Not Known

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Mayer Schiff

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Hartman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Sister-Miss Amelia Schiff

(Address) Eglinton Apts

15 Filed JUL 3 1927, 19 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to July 1, 1927, that I last saw him alive on July 1, 1927, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY Myocarditis (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray & typical signs

(Signed) James Crellin Knudsen, M. D.

19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem — Date of Burial: July 3 1927

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1730 Eutaw Pl

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23615

CERTIFICATE OF DEATH.

129 E 23615

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 707 N. Spring St 16-13 Ward)

2-FULL NAME George Walker

(a) RESIDENCE NO. 707 N. Spring St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Walker

6 DATE OF BIRTH (month, day, and year) Oct 15/1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	42	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Walker

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Enos

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Unknown

14 Informant Mamie Walker

(Address) 707 N. Spring St.

15 Filed _____ 19 H. [illegible] Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/37 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia (terminal),

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary) History Nephritis & retention Uri[illegible]

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jos H Coles M. D.

(Coroner)

7/1/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial 7-4 1927

20 UNDERTAKER Jas. Jno. Skinner ADDRESS 1625 E. Fred. St

Instructions on back of certificate.

Name, residence and occupation of informant.

Cause of death must be stated.

Duration of disease must be stated.

Name of attending physician.

Time of death must be stated.

Place of death must be stated.

Name of deceased must be stated.

Date of death must be stated.

Name of undertaker must be stated.

Place of burial must be stated.

Date of burial must be stated.

Name of cemetery must be stated.

Name of city or town must be stated.

Name of county must be stated.

Name of state must be stated.

Name of country must be stated.

Name of parents must be stated.

Name of mother must be stated.

Name of father must be stated.

Name of spouse must be stated.

Name of children must be stated.

Name of grandparents must be stated.

Name of great-grandparents must be stated.

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Name of great-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 23616

CERTIFICATE OF DEATH.

E 23616

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1502 N. Laur 1627 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Johnson

(a) RESIDENCE NO. 1502 N. Laur St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Johnson

6 DATE OF BIRTH (month, day, and year) July 3. 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	11	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Emma Johnson

(Address) 1502 N. Laur St

15 Filed JUL 5 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) C. C. Hampson Jones M. D.

(Coroner)

July 3, 1927 (Address) 2802 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial July 3 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 303 Hesselman

Spec.—1-12-23—M&T—500 Blks.

E 23617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 E 23617

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3612 Sycamore ST. 13 WARD

REGISTERED NO. 1357

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza J. Ehrest

(a) RESIDENCE NO. 3612 Sycamore ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Ehrest

6 DATE OF BIRTH (month, day, and year) Jan. 12-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover, Pa.

PARENTS

10 NAME OF FATHER Peter Wasenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant William H. Ehrest (Address) 3612 Sycamore St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1- 1927

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to July 1, 1927.

that I last saw her alive on July 1, 1927

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senarii & arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical findings

(Signed) J. Wilson M. D.

19 (Address) 823 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Hanover Pa. DATE OF BURIAL July 5 1927

20 UNDERTAKER Grace F. Burgee ADDRESS 3431 Falls Rd

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23618

CERTIFICATE OF DEATH.

94-E 23618

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2139 Wallbrook Ave St. 15-68 WARD)

2-FULL NAME Alexander C. Orr

(a) RESIDENCE NO. 2139 Wallbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie B. Orr

6 DATE OF BIRTH (month, day, and year) May 13-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Joseph Orr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Elizabeth Guthrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mrs. Hattie B. Orr

(Address) 2139 Wallbrook Ave

15 Filed JUL 3 - 1927 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1- 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1st 1927 to July 1st 1927.

that I last saw h[illegible] alive on July 1st 1927

and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH was as follows:

Bronchiectasis (static pneumonic type

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Nephritis (glomerular

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Seymour Pierce, M. D.

7-2 1927 (Address) 2202 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monkton (Balto. Co.) DATE OF BURIAL July 4 1927

20 UNDERTAKER Grace F. Burgee ADDRESS 3631 Falls Rd

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23619 — 57 E 23619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3327 Gwynns Falls Pky St. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Vinton Harvey

(a) RESIDENCE NO. 3327 Gwynns Falls Pkwy St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Barton Harvey

6 DATE OF BIRTH (month, day, and year) Jan 4 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	67	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co

PARENTS

10 NAME OF FATHER Thomas L Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Alice Barton Harvey (Address) 3327 Gwynns Falls Pkwy

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1927 to July 1st 1927.

that I last saw him alive on June - 30th 1927

and that death occurred, on the date stated above, at 3 - A m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

Bronchio - Pneumonia

(duration) yrs 1 mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory file

(Signed) C. Murfee Jones, M. D.

July 3 1927 (Address) 1704 N Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 5 1927
20 UNDERTAKER	ADDRESS
S. M. Jackson Sons	Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23620

CERTIFICATE OF DEATH.

90 E 23620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 N. Fulton Ave St. 1521 WARD)

2-FULL NAME Elijah Bell Tarbutton

(a) RESIDENCE NO. 1937 N. Fulton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if at foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie B. Tarbutton

6 DATE OF BIRTH (month, day, and year) June 6-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Annie B. Tarbutton (Address) 1937 N. Fulton Ave

15 Filed JUL 2 - 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1, 1927, to 7-1, 1927, that I last saw h— alive on 6-30, 1927, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Burgoyne M. D.

7/2, 1927 (Address) 1928 E. Fulton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL July 4 1927

20 UNDERTAKER Wm. J. Tuckerman & Sons ADDRESS N. Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

E 23621

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23621

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1808 Dukeland St. 15-68 (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna L. Flathmann Flathmann

(a) Residence No. 1808 Dukeland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Flathma

6-DATE OF BIRTH (month, day and year) Jan 24 1886

7-AGE. 41 yrs. 5 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto (State or Country).

PARENTS.

10-NAME OF FATHER, James Moffett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mollie Burley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Henry Flathmann

(Address) 1808 Dukeland St

15- Filed 6 HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7-1-27

17- I HEREBY CERTIFY, That I attended deceased from 1/4, 1927 to 7-1, 1927

that I last saw h. alive on 7-1- 1927

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows

Myocardial insufficiency and Acute Cardiac Dilatation

(Duration) yrs. mos. 1- ds

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) yrs. 6 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Miller M. D.

7-2, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. July 5 1927

20-UNDERTAKER. Wm J Tickner Sons

ADDRESS N. Y Pa

Spec.–7-17-26—A Co.—200 Bks.

23622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. E 33622

City of BALTIMORE: (No. 33rd & Calvert St. 1567 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William J. Graham

(a) RESIDENCE NO. 3217 Vickers Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bertha S. Mrs ~~Wm.~~ J. Graham

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	62	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER J. E. Graham

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Jefferson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant ~~Wife~~ Bertha S. Graham

(Address) 3217 Vickers Road

15 Filed JUL 3 1927 16 HAMPSON JONES, M. D. Registrar

Per R/K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927 to July 2, 1927, that I last saw him alive on July 2, 1927, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. & Lab.

(Signed) James Arthur Lowndes, M. D.

19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial July 5 1927

20 UNDERTAKER Wm. Tickner Sons ADDRESS North Ave.

Important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 23623

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23623

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5202 Garrison Ave (ST.) 27-5 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Glenn Fallsenberg

(a) RESIDENCE No. 5202 Garrison Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13th 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	1	7	16	19.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Edward J. Fallsenberg

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Norah R. McGuckin

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Edward J. Fallsenberg (Address) 5202 Garrison Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 2, 1927,

that I last saw him alive on July 2, 1927

and that death occurred, on the date stated above at 5 A m

The CAUSE OF DEATH* was as follows:

Congenital Enlarged Thymus

(duration) Lifetime yrs. mos ds.

CONTRIBUTORY (Secondary) Haemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Those of Enlarged Thymus

(Signed) Walter C. Bacon, M. D.

7/2 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount St. Edwards Cemetery

DATE OF BURIAL July 5 1927

20 UNDERTAKER Lilly & Gruber

ADDRESS 403 E. Monument St

7-2-1927 C. HAMPTON JONES, M. D.

R/C

See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23624

CERTIFICATE OF DEATH.

E 23624

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 12-57 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Phillips

(a) RESIDENCE NO. 937 Bevan St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Hommier Phillips

(Address) 937 Bevan St

Filed JUL 3 1925 HAMPSON JONES, M. D.

Ref. K.M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 2 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

July 3, 19 25 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial July 5 1925

20 UNDERTAKER A. Jones ADDRESS 111 S Gilmor

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23625

CERTIFICATE OF DEATH.

E 23625

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 9-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James Adams

(a) RESIDENCE NO. Akron - Ohio St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-25-26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		11	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER Howard Adams

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Grace Axtell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records -

(Address Johns Hopkins Hospital)

15 Filed JUL 3 1927 C. HAMILTON JONES, M. D. Per H.H.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to July 3, 1927, that I last saw him alive on July 3, 1927, and that death occurred, on the date stated above, at 7 35 m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus (Obstructive)

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 5/9/27; 6/2/27

Did an operation precede death? Yes Date of 7/2/27

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of brain at autopsy

(Signed) George G. Finney M. D.

7/3/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Akron Ohio — Date of Burial: July 5 1927

20 UNDERTAKER: J. O. Mitchell — ADDRESS: 400 Eastern

Sec. 39 of the Code requires the Undertaker to report the Cause of Death if the Physician fails to do so. See back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23626

CERTIFICATE OF DEATH

8 8 E 23626

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD 13)

2-FULL NAME David J Shea

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 3-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	66	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. Section Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) R. Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Waterford Pa

PARENTS

10 NAME OF FATHER Michael Shea

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Conners

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat

15 Filed ..... 19 1927 C. HAMPTON JONES, M. D. Registrar

Per R.L.C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1919, to July 3rd, 1927, that I last saw him alive on July 2nd 1927, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis, —

(duration) 8 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis Chr —

(duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Waterford Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

July 3rd, 1927 (Address) Mt Hope Retreat —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa

DATE OF BURIAL July 4th 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 105 W. NORTH AV

Spec.—1-12-23—M&T—500 Blks.

E 23627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 23627

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1120 W. Fayette ST. (Ave.) 18-26

2-FULL NAME Virginia Mason Bowersox

(a) RESIDENCE No. 1120 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ (or) ~~HUSBAND~~ of WIFE of J J Bowersox

6 DATE OF BIRTH (month, day, and year) Feb 16 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
✓	60	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George F. Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER b Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) J. J. Bowersox 1120 W Fayette St

15 Filed JUL 4 - 1927 HAMILTON LOWE, M. D. Registrar

16 Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to July 2nd, 1927, that I last saw her alive on July 2nd 1927 and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency with Acute Dilatation of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Myocardial Insufficiency

(Signed) J A Bolton M. D.

July 3, 1927 (Address) 1300 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: July 5 1927

20 UNDERTAKER: Henry J Jenkins & Sons Co — ADDRESS: Cleveland & Cathedral Sts

See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23628

CERTIFICATE OF DEATH.

113

E 23628

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 So. Calhoun St. 14-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Young

(a) RESIDENCE NO. 404 So Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 13 / 26

7 AGE: Years 1 Months — Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Oscar M. Young

11 BIRTHPLACE OF FATHER (city or town): Walsh, Md

(State or country)

12 MAIDEN NAME OF MOTHER: Grace N. Emmart

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Grace N. Young

(Address): 404 So. Calhoun St

15 Filed 4-1927, 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest authorized by inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (by autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Infantile Convulsions

Intestinal Indigestion

CONTRIBUTORY (Secondary)

(Signed) Wm. B. Norton M. D.

(Coroner)

July 27 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial July 29 27

20 UNDERTAKER: Wm Cook ADDRESS 502 E North

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23629

E 23629

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 3729 Mt Pleasant St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Foster

(a) RESIDENCE NO. 3729 Mt. Pleasant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10. 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER Wm. H. Foster

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Bennie Seymour

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant Mrs. Wm. H. Foster

(Address) 3729 Mt Pleasant

15 Filed , 19 JUL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20 19 27, to July 2 19 27, that I last saw h[illegible] alive on July 2 19 27, and that death occurred, on the date stated above, at 1-15 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Myocarditis, nephritis

(duration) yrs. 5 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical

(Signed) M. D.

, 19 (Address) 479 N. Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Date of Burial July 5 1927

20 UNDERTAKER H. Cole & Son ADDRESS Baltimore

See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23630
1-PLACE OF DEATH

88 E 23630
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 5016 Elmer Ave ST. 27-5 (WARD)

2-FULL NAME Joseph E. Stapf

(a) RESIDENCE NO. 5016 Elmer Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula Stapf

6 DATE OF BIRTH (month, day, and year): Sept 9, 1901.

7 AGE: Years 25 Months 9 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Fairfield Farms Baltimore Md

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John A. Stapf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Katie E. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs John A. Stapf
(Address) 5016 Elmer Ave

15 Filed JUL 4 - 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2, 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927. to July 2, 1927.
that I last saw him alive on July 1, 1927
and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Embolism

(duration) yrs. ½ mos ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. L. Pearson M. D.
7.2.27. 19 (Address) 514 Drury Lane,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Torrance Cemetery — DATE OF BURIAL: July 5 1927

UNDERTAKER: Williams Cook — ADDRESS: 502 E Mt

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23631 E 23631

CERTIFICATE OF DEATH.

REGISTERED NO. 88 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) North Point Rd at B&O RR-38 (St.) (WARD)

2-FULL NAME Minnie M Daughton

(a) RESIDENCE No. Jarrettsville Harford Co Md (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E Daughton

6 DATE OF BIRTH (month, day, and year) Dec 26 1879

7 AGE Years 47 Months 6 Days 5 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home duties

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Jno Pickett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant William E Daughton

(Address) Jarrettsville Md

15 Filed JL 4 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927 to July 3 1927

that I last saw her alive on July 2 1927

and that death occurred, on the date stated above, at 7-10 p m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Jarrettsville Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M L Spurrier M. D.

7-3 1927 (Address) 682 Whitelock Bal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jarrettsville Cemetery

DATE OF BURIAL July 6 1927

20 UNDERTAKER E G Kurtz & Son

ADDRESS Jarrettsville Md

HAMPSON, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23632

E 23632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 N. Edgewood ST. 16-67 WARD)

REGISTERED NO. 74-581

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Amey

(a) RESIDENCE NO. 756 N. Edgewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Amey

6 DATE OF BIRTH (month, day, and year) 9-15-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. Amey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adel. Labrot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mr. Amey
(Address) 756 N. Edgewood

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7- -27

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 2, 1927, that I last saw h[illegible] alive on July 1, 1927, and that death occurred, on the date stated above, at 1:30 A m

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) yrs. 3 mos 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hampson M. D.

7/6/27 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet.

DATE OF BURIAL 7/5 1927

20 UNDERTAKER J. F. McCaffrey

ADDRESS 430 E. Fort

7-1-1927 HAMPSON JONES, M. D.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23633 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 23633**

CERTIFICATE OF DEATH.

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 3813 Virginia ave. St. Raspeburg Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Fiddis

(a) Residence No. 3813 Virginia ave. St. Raspeburg Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John S. Fiddis

6-DATE OF BIRTH (month, day and year) Oct 4th 1885

7-AGE, 41 yrs. 8 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) Philadelphia (State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER, James Graydon

11-BIRTHPLACE OF FATHER (city or town) Glascow (State or Country) Scotland

12-MAIDEN NAME OF MOTHER, Elizabeth Tracey

13-BIRTHPLACE OF MOTHER (city or town) Dublin (State or Country) Ireland

11- (Informant) John S. Fiddis

(Address) 3813 Virginia ave. Raspeburg

15-

Filed 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 2nd 1927

17- I HEREBY CERTIFY, That I attended deceased from June 25 19 26 to July 2 19 27, that I last saw h. alive on July 1st 19 27, and that death occurred, on the date stated above, at 1245 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Tests

(Signed) Edward Reuter M. D.

July 7. 1927 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Arnd Ridge Cemetery — DATE OF BURIAL, July 5th 1927

20-UNDERTAKER, Frederick Lassahn & Son — ADDRESS Fullerton Md.

RAL

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23634

1-PLACE OF DEATH

REGISTERED NO. 129 E 23634

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3221 Guilford Avenue ST., 12-5 WARD)

2-FULL NAME William A. Houston

(a) RESIDENCE NO. 3221 Guilford Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Asame

6 DATE OF BIRTH (month, day, and year) July 10, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Jos. Dixon

(c) Name of employer Crucible Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joel Houston

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Hattie Almony

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Mrs. Minnie Houston
(Address) 3221 Guilford Avenue

15 Filed ..., 19... W. HAMILTON JONES, M. D. Registrar

4-1927 For RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to July 2, 1927, that I last saw h~~e~~ alive on July 2, 1927, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. 3 ds.

(duration) 16 yrs. 16 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon M. D.

7/3, 1927 (Address) 718 N Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	7/5 19 27
20 UNDERTAKER Henry U. Mears & Son	ADDRESS 805 N Calvert

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23635

CERTIFICATE OF DEATH.

E 23635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Frederick Ave ST., 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Weesan.

(a) RESIDENCE NO. 2322 Frederick ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~(Husband of)~~ or) WIFE of George Weesan

6 DATE OF BIRTH (month, day, and year) ? ? 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER N. Millei

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Rosa Knapp (Address) 2125 Ramsay St.

15 Filed — 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1926, to July 2, 1927, that I last saw h alive on July 1, 1927 and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of about 10 mos ago

Was there an autopsy? no

What test confirmed diagnosis? Laparotomy

(Signed) Reynolds DeLee M. D.

7/3, 1927 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 7/5/27

20 UNDERTAKER Harry A Weitzel — ADDRESS 1031 W Lombard St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 23636 REGISTERED NO. E 23636

City of BALTIMORE: (No. Provident Hospital St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Snowden

(a) RESIDENCE NO. 1002 E. Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Snowden

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years 47 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER John W. Johnson

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Josephine Sutton

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md.

(State or country)

14 Informant Randolph Snowden

(Address) 1002 E. Madison St.

15 Filed July 1 1927 C. HAMPSON JONES, M. D. Registrar

Per R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 18 19 27 to June 30 19 27

that I last saw her alive on June 30 19 27

and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Ludwick's Angina

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) John W. Gamer, M. D.

, 19 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Actons Cemetery Date of Burial July 4 19 27

20 UNDERTAKER Chas. H. Johnson ADDRESS 46 N. Carrollton Ave.

Please write plainly and follow instructions on back of certificates. Make statement of OCCUPATION in

Spec.—1-12-23—M&T—500 Blks.

23637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO. E 23637

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Manchester Apt ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gus Oppenheim

(a) RESIDENCE NO. Madison Ave & Bloom St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

◆ DATE OF BIRTH (month, day, and year) Dec 26/1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jacob Oppenheim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Bertha Oppenheim (Address): Manchester Apt

15 Filed 4 1927 19 R.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to July 3, 1927, that I last saw h[illegible] alive on July, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Asthma Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory —

(Signed) J J Love, M. D.

, 19 (Address) 836 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Club Shalom — DATE OF BURIAL: July 5 1927

20 UNDERTAKER: Nat Goodheim — ADDRESS: 1114 Mt Royal

E 23638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 E 23638

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 Fleet ST.; Brook WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Brady

(Residence in Baltimore: No. 1509 Fleet St., 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, April (Month) 28. (Day), 1887. (Year)

7-AGE,	If LESS than 1 day,
40 yrs. 2 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): for Family

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER, Brady

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Brady

(Address) 2623 Eutaw St

15-

Filed July 4 - 1927 191

C. HAMPSON JONES, M. D.
Per R. K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

Edema of Legs (Duration) yrs. 2 mos. ds.

(Signed) John M Fenton M. D.
(Coroner.)

July 3, 1927. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Eastern Cem. DATE OF BURIAL, July 4, 1927

20-UNDERTAKER Wendell J. Lippy ADDRESS 300 N. Eden St.

Spec.—1-12-23—M&T—500 Bks.

E 23639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 E 23639

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3617 Springdale Ave ST. 15-61 (WARD)

2-FULL NAME Ada Ruth Rome

(a) RESIDENCE No. 3617 Springdale Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 28 - 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Havre de Grace Md

PARENTS

10 NAME OF FATHER Samuel H Rome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah Hymes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel H. Rome

(Address) 3617 Springdale Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1926, to July 3, 1927, that I last saw h alive on July 3 1927 and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis (Streptococcus viridans)

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolus.

(duration) — yrs. — mos. 1 ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood culture Etc

(Signed) Louis P. Hamburger, M. D.

July 4, 1927 (Address) 1707 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mahrem Mach Cd

DATE OF BURIAL July 4 1927

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balt St

JUL 1927 C. HAMPSON JONES, M. D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23640

E 23640

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2922 Cedar Ave St. 42-51 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Williams

(Residence in Baltimore: No. 2922 Cedar Ave St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W

5-Single, Married, Widowed or Divorced, (Write the word.) Married

6-DATE OF BIRTH. July (Month) 25 (Day) 1889 (Year)

7-AGE. 38 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Plumber
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS

10-NAME OF FATHER. Enoch Williams

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Williams

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula F. Williams

(Address) 2922 Cedar Ave

15-

Filed Nov 4 1920 1921 HAMPSON JONES, M. D. Registrar.

per .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) July (Day) 1 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to *Violent death on the day stated above.

The CAUSE OF DEATH was as follows: Jabular Thrombosis of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

(Coroner.)

1927 (Address) 2922 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Pleasant Carroll 60 DATE OF BURIAL. June 5 1927

20-UNDERTAKER. Shewmaker ADDRESS 3615 Chestnut Ave

Spec.–7-17-26–A Co.–200 Bks

See Letter in file from Dr. C. H. Boyd adding Robert to the certificate. Dated JUL 12 192

E 23641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23641

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. [redacted] ST.) (Ward) 13-3K

(If death occurred in a hospital or institution, give its NAME instead of street and number.) BALTIMORE CITY HOSPITALS

2-FULL NAME Robert Francis Grimes.

(a) RESIDENCE NO. 700 W. 34th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Grimes

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 6-40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Residence

15 Filed ..... 19 ..... Registrar

L 4 - 1926

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/1927.

17 I HEREBY CERTIFY, That I attended deceased from June 24. 1927. to July 3. 1927

that I last saw him alive on July 3. 1927

and that death occurred, on the date stated above, at 8:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic & arteriosclerosis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Gale.

(Signed) C. Holmes Boyd, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Marys Hampden July 5 1927

20 UNDERTAKER — ADDRESS

Chenoweth & Son Chestnut 1617

Please see instructions on back of certificates. Insert statement of OCCUPATION in

Alton.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23642

CERTIFICATE OF DEATH

129 E 23642

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1338 W Lafayette St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alton

(a) RESIDENCE NO. 1338 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: Years 63 Months — Days —

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Geo R Wallace

(Address) 1338 W Lafayette ave

15 Filed JUL 4 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1927 to July 2 1927,

that I last saw h[illegible] alive on July 2, 1927,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Primary cause: Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/7/27 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cookes Chapel Md — Date of Burial July 5 '27

20 UNDERTAKER: Wood Forbes — ADDRESS Balto

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23643

CERTIFICATE OF DEATH.

90 E 23643

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1000 S. 3d ST. No. 37 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Williams

(Residence in Baltimore: No. 1000 S. 3d St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... Nov (Month) 28 (Day), 1845 (Year)

7-AGE, ... 61 yrs. 6 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ..... City 7 Field 0 0

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wm Williams

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Williams

(Address) 1000 S 3d St

15-

Filed ..... 194.. C. HAMPTON JONES, M. D. Registrar.

JUL 4 - 1927

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 3 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis
from Arteriosclerosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(Duration) 3 yrs. mos. ds.

(Signed) James M. Hinton M. D. (Coroner.)

7-3-, 1927 (Address) 704 Cleveland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel — DATE OF BURIAL, July 6, 1927

20-UNDERTAKER Peter Nicolaus — ADDRESS 1930 Eastern

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23644

CERTIFICATE OF DEATH.

59-002

E 23644

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 27-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Hiss, Jr

(a) RESIDENCE NO. 718 Hollen Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year) June 30/27

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of indnstry, bnsiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas. W. Hiss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Ada L. Glass

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Chas. W. Hiss

(Address) 718 Hollen Rd

15 Filed JUL 4 1927 16 Registrar H. H. Jones M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malformation of heart.

(Autopsy at Hopkins.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Bruns M. D. (Coroner)

7/4/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial July 4 1927

20 UNDERTAKER Wm. C. Miller & Son ADDRESS 2334 E. Monument St.

Spec.-7-17-26—A Co. 3200 Bks.

E 23645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 23645

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 Eislen St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Washington

(a) RESIDENCE NO. 630 Eislen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. - mos. - ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): — 1887

7 AGE: Years 40 Months - Days - IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: McCurdy Fox Factory

9 BIRTHPLACE (city or town): West River

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Ernest Johnson

11 BIRTHPLACE OF FATHER (city or town) West River

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mittie Johnson

13 BIRTHPLACE OF MOTHER (City or town) West River

(State or country) Maryland

14 Informant: Charlotte Washington

(Address) 630 Eislen St.

15 Filed JUL 4 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1926, to 6/30, 1927, that I last saw h.. alive on 6/30 1927, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurysm

(duration) 1 yrs 3 mos 0 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dan Francheon M. D.

7/4, 1927 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial 7/4 1927

20 UNDERTAKER: J Leon Hall ADDRESS 753 Dolphin St

If the space provided for the answer to any question is insufficient, use the reverse side of this certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23646 — 43 E 23646

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

City of BALTIMORE: (No. Calvert & 33rd St., 27-53 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. C. Meikle

(a) RESIDENCE NO. 509 Keswick Rd Roland Pk St. Ward (Residence)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 24 ds. How long in U. S. if of foreign birth? 54 yrs. 9 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs J. W. C. Meikle

6 DATE OF BIRTH (month, day, and year) 9/8/72

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	54	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery Co

(c) Name of employer Rasse & Rasse Md

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER James Meikle

11 BIRTHPLACE OF FATHER (City or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Locken

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country)

14 Informant Mrs Helen H. Meikle (Address) 509 Keswick Road

15 Filed ..... 19 ..... Registrar ..... Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 19 27 to 7/2, 19 27, that I last saw h— alive on 7/2, 19 27, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue a Metastasis to Cervical gland

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/30/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem — Date of Burial July 5 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

Instructions on back of certificates. Statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

E 23647 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Hope Retreat

CITY OF BALTIMORE: (No. 7 ST. 7-55 WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. McConnell

(a) RESIDENCE NO. 107 Rogers ave ST., WARD 2 Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? 61 yrs. 11 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady.

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. McConnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Ireland

12 MAIDEN NAME OF MOTHER Jane Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Ireland

14 Informant Mrs Hope Reeves (Address) Mrs Hope Retreat.

15 Filed 1927 19 H. A. T. P. N. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from October 29, 1926, to July 3, 1927, that I last saw h alive on July 3, 1927, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Gastro-Enteritis)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Depressive Psychosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Milton P. Reed, M. D.

, 19 (Address) Mrs Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL July 6 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23648

CERTIFICATE OF DEATH

74-001 × 74 E 23648

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 29 S Pulaski St., Ward 20-28)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Law

(a) RESIDENCE NO. 29 S. Pulaski St. Ward Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 10 1866

7 AGE: Years 60. Months 11 Days 21 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER Richard Law

11 BIRTHPLACE OF FATHER (City or town) England

(State or country)

12 MAIDEN NAME OF MOTHER Mary Daly

13 BIRTHPLACE OF MOTHER (City or town) Ireland

(State or country)

14 Informant Wm J Law

(Address) 29 S Pulaski

15 Filed ..... 19 ..... Registrar R M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 19 27.

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to July 2, 1927.

that I last saw h. alive on July 2, 1927.

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Central Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. H. Wiesenfarth, M. D.

, 19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 7/5 19 27

UNDERTAKER Geo A Fuhrman ADDRESS Fulton & Fayette

Instructions on back of certificates. Statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23649
1-PLACE OF DEATH

90 E 23649
REGISTERED NO.

City of BALTIMORE: (No. 131 N. Duncan St., 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Charvat

(a) RESIDENCE NO. 131 N. Duncan St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Charvat

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.... hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Charvat

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Bohemia

14 Informant: Barbara Charvat
(Address): 131 N Duncan St

15 Filed: JUL 5 1927 G. HAMPSON JONES, M. D.
Per R.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5 1927, to July 1 1927, that I last saw h.... alive on July 1 1927, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble
(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rysavy M. D.
(Address) 801 N Chester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: July 5 1927

20 UNDERTAKER: Frank Cracknell Son — ADDRESS: 1906 Eastern Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23650 (1-PLACE OF DEATH)

REGISTERED NO. 10-20 E 23650

City of BALTIMORE: (No. 325 East 21st St., 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Bernhard jr.

(a) RESIDENCE NO. 325 E 21st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 30 1922

7 AGE: Years 4 Months 11 Days 3. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country) Md.

PARENTS

10 NAME OF FATHER Wm E. Bernhard Sr.

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel T Ambrose

13 BIRTHPLACE OF MOTHER (city or town) Cockeysville (State or country) Md.

14 Informant Wm E. Bernhard (Address) 325 E. 21st St.

15 Filed JUL 4 1927 C. HAMILTON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28 1927 to July 3rd 1927.

that I last saw him alive on July 3rd 1927.

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ac. Follicular Tonsillitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Arthur C Mannnagh M. D.

7-4. 1927 (Address) 323 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: July 5 1927

20 UNDERTAKER: J Walter Lane — ADDRESS: 337 Paine St

Important: See instructions on back of certificates. Statement of OCCUPATION is required.

Spec. –7-17-26—A Co.—200 Bks.

Helen I Hood

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23651

CERTIFICATE OF DEATH

117

E 23651

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp St., or (Ward) 30-4-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Helen I Hood

(a) RESIDENCE NO. 2226 Linwood Av Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emory L. Hood

6 DATE OF BIRTH (month, day, and year): November 12, 1907 1907-11-12

7 AGE: Years 19 Months 7 Days 20

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Chas Kramer

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Emma Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Address): Hosp Records

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 1927-7-1

17 I HEREBY CERTIFY, That I attended deceased from 6/24/27, 19, to 7/1/27, 19, that I last saw h alive on 7/1/27, 19, and that death occurred, on the date stated above, at 12 55 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Puerperalis

Endocarditis

Post Partum Eclampsia (duration) 7 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 6/27/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Timmons Jr M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: July 19 27

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1800 W. Baltimore St

JUL 4 - 1927

C. HAMPSON JONES, M.D.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23652
1-PLACE OF DEATH

161-002 E 23652
REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital 14-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby (Boy) Mallonee

(a) RESIDENCE NO. 5 Seminole Ave. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-1-1927

7 AGE: Years / Months / Days 2

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo. Price Mallonee

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Edith Margaret Herr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant George P. Mallonee
(Address) 5 Seminole Ave Catonsville

15 Filed JUL 4 - 1927 HARRY JONES, M. D.
Registrar
Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/1, 1927, to 7/3, 1927

that I last saw him alive on 7/3, 1927,

and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Cyanosis and Cerebral Hemorrhage
Premature

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. Robertson, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — Date of Burial: July 4 1927

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 W Balto

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23653

CERTIFICATE OF DEATH

129 E 23653

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1225 N. Calvert Street St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Brooks Hubbell

(a) RESIDENCE NO. 1225 N. Calvert Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth E.B. Hubbell

6 DATE OF BIRTH (month, day, and year) July-21-1842

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	84	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Harrisburg

(State or country) Penna.

PARENTS

10 NAME OF FATHER Horatio Hubbell

11 BIRTHPLACE OF FATHER (City or town) ? ?

(State or country) New York

12 MAIDEN NAME OF MOTHER Rebecca Brooks

13 BIRTHPLACE OF MOTHER (city or town) Harrisburg

(State or country) Penna.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 2. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 8. 10, 19 25 to July 2, 19 27.

that I last saw him alive on July 2, 19 27

and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension-Pyelitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas F. Magner M. D.

7/4. 19 27 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Mrs. Elizabeth E.B. Hubbell (wife)

(Address) 1225 N. Calvert Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Hill Cemetery, Phila. Penna.

Date of Burial 7/5 1927

15 Filed 19

C. HAMPSON JONES, M.

Registrar

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS

DEC 5 - 1927

For instructions on back of certificates.

Statement of OCCUPATION is

Spec. -7-17-26—A Co.—200,Bks.

(Morgan Mitchell)

E 23654

HEALTH DEPARTMENT—CITY OF BALTIMORE

+ 179 E 23654

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Mitchell

(a) RESIDENCE NO. Aberdeen Md. — Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 0 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal.

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Mitchell

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE: Years 72 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md —

(State or country)

PARENTS

10 NAME OF FATHER: John Mitchell

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records

(Address): Mercy Hospital

15 Filed 7 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per E 179

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-4-27 19 to 7-4-27 19

that I last saw him alive on 7-4-27 19

and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia. + Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.M. findings

(Signed) Emmett [illegible] M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Grove Cemetery Aberdeen Md. Date of Burial: July 7 1927

20 UNDERTAKER: Henry W. Means & Son ADDRESS: 805 N. Calvert St.

Instructions on back of certificate.

Statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23655

CERTIFICATE OF DEATH.

31

E 23655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2604 E. Balto. St. 6-10 Ward)

2-FULL NAME Edward A. Ruth

(a) RESIDENCE NO. 2604 E. Balto. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 28 1905

7 AGE: Years 22 | Months 1 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Ruth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Virginia Spencer

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Mr. Jos. Ruth

(Address) 2604 E. Balto st

15 Filed ..... 19 ..... Registrar

5-1927 By GKG

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 2- 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1927 to July 2, 1927, that I last saw h.. alive on July 2, 1927, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tbc. of Intestines 1 week - Tbc. of Larynx - 2 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray - Sputum

(Signed) Lam F. Krumrein, M. D.

19 (Address) 722 N. Kenwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial July 6 1927

20 UNDERTAKER: Jos. J. Berrodon ADDRESS 1502 N. Luzerne

Spec.–7-17-26—A Co.—200 Bks.

E 23656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

202

E 23656

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph Hospital St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mc Kelvey

(a) RESIDENCE NO. 835 Ashland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9-1918

7 AGE Years: 8 Months: 9 Days: 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City

(State or country)

PARENTS

10 NAME OF FATHER Edgar. Mc Kelvey

11 BIRTHPLACE OF FATHER (City or town) Balto Co

(State or country)

12 MAIDEN NAME OF MOTHER Minnie Coale

13 BIRTHPLACE OF MOTHER (City or town) Balto Co

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 19 GHG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1927 to July 2nd 1927

that I last saw him alive on July 2nd 1927

and that death occurred, on the date stated above, at 4½ pm.

The CAUSE OF DEATH* was as follows:

Ostitis (purulent) Skull

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Brain Abscess.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? yes Date of June 27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clement R. Monroe M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jessup Md. Balto Co

Date of Burial: July 5 1927

20 UNDERTAKER: A S Marshall

ADDRESS: 2539 Fall Rd

TRUST HAMPTON JONES

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23657

CERTIFICATE OF DEATH.

129 ✓ E 23657

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 1609 E Lombard St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Clauss

(a) RESIDENCE NO. 1609 E Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Feb 20 1850

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Emanuel Clauss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary E. Sparbier

(Address) 274 Curley St

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) few hrs. yrs. mos. ds.

(Signed) James M Fenlon M. D.

(Coroner)

7/5, 1927 (Address) 709 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem. Date of Burial July 6 1927

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eden St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

E 23658

E 23658

CERTIFICATE OF DEATH.

LUEBECK

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St. 26 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman C. Luebeck

(a) RESIDENCE NO. 324 28 Darentine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 8 mos. 23 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Oct 9th 1913

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	13	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer School # 215

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Herman Leubeck

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Gundel

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Herman Leubeck

(Address) 3428 Dearborn ave

15 Filed ..... 19 C. HAMPSON JONES, M. D.

By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fire Cerebral Auto Acc

Multiple Fractures Instant

(duration) yrs. almost ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

July 4 1927 (Signed) Geo Clinton Radcliff M. D.

(Coroner)

(Address) 436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Lombard & 3rd St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial 7/5 1927

20 UNDERTAKER Geo. W. Burton Son ADDRESS 2503 Edmon

Spec.—1-12-23—M&T—500 Bks.

E 23659 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23659

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3504 Southern Ave (St.) 15-61 (WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Cochrane

(a) RESIDENCE No. 3504 Powhattan Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard M Cochrane

6 DATE OF BIRTH (month, day, and year) July 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

10 NAME OF FATHER Stood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

Informant Mrs Alfred Rice

(Address) 3502 Powhattan Ave

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to July 3, 1927.

That I last saw h[illegible] alive on July 3, 1927

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzger, M. D.

July 3 1927 (Address) 1903 W. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 6 1927

20 UNDERTAKER P. J. Lawrence Sons

ADDRESS Norther[illegible]

E 23660

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23660

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arlington Po- Old 6 mile House, WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Infant of William F & Mary L Wilhelm

(Residence in Baltimore: No. Pikesville Rd near Mt Hope Lane St., ... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, July 3, 1927.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 12 hrs. or 20 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... nothing
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm F Wilhelm

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Mary Lydia Warner

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F Wilhelm

(Address) Arlington md

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4, 1927.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1927, to July 3- 1927, that I saw h er alive on July 3- 1927, and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Prematurity 8 hrs

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Nichols M. D.

July 4, 1927 (Address) Pikesville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Cem. Co. Lazarus Mount Lem

DATE OF BURIAL, July 5, 1927

20-UNDERTAKER Louis A. Merle

ADDRESS Pikesville Md.

Filed July 5 - 1927 C. HAMPSON JONES, M.D. Registrar

E Hy

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23661 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 49

City of BALTIMORE: (No. 3405 Greenway St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Washington Biddle

(a) Residence No. 3405 Greenway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W

5-~~MARRIED~~, Married, Widower, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~WIFE~~ or ~~HUSBAND~~ of ~~THE~~ HUSBAND of Virginia L. Biddle

6-DATE OF BIRTH (month, day and year) Feb. 22. 1857

7-AGE. 70 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerical 09

(b) General nature of industry, business, or establishment in which employed (or employer) Appeal Tax Court

(c) Name of employer City of Baltimore

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Johnathan K. Biddle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Susan Fhrman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Eugene L. Norton

(Address) 4207 Greenway

15- Filed July 5 1927 [illegible] Registrar.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3. 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1927 to July 3 1927

that I last saw h[illegible] alive on July 2. 1927,

and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Ostes - Sarcoma

(Right pelvis)

Abt (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Leukemia

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Home

(Signed) H. V. Stansbury M. D.

. 19 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. July 5th 1927

20-UNDERTAKER. [illegible] Funeral Chs

ADDRESS 424 N. Broadway

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23662

CERTIFICATE OF DEATH

31 E 23662

1-PLACE OF DEATH Balto. City Hospitals — REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Holden

(a) RESIDENCE NO. 605 Mt. Auburn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): July 25, 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	39	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Wm Holden

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Jane Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Hospital Records (Address): Balto City Hospitals

15 Filed JUL 5 - 1927 — C. HAMPSON JONES, M. D. Registrar — Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to July 2, 1927, that I last saw him alive on July 2, 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Tb. peritonitis (Ulcerative)

unknown (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) C. Hampson Jones, M. D.

7.4.1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Olivet Cemetery	July 5 1927
UNDERTAKER: Wm Cook	ADDRESS: 502 E North Ave

Instructions on back of certificates. Statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23663

CERTIFICATE OF DEATH.

90 E 23663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 East Federal St. 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estie Haynes

(a) RESIDENCE No. 1608 East Federal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Harry E. Haynes

6 DATE OF BIRTH (month, day, and year): 12-16-1875

7 AGE: Years 51 | Months 6 | Days 17 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Lanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Bentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Harry E Haynes

(Address) 1608 East Federal

15 Filed JUL 5 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-3 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-7, 1927, to 7-3, 1927

that I last saw h[illegible] alive on 7-3, 1927

and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

7-3, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 7/6 1927

M UNDERTAKER: [illegible] Cook Co

ADDRESS: 502 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23664

CERTIFICATE OF DEATH.

182 E 23664

1-PLACE OF DEATH. Found in Harbor

City of BALTIMORE: (New) Carolina St. 22-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Harper

(a) RESIDENCE NO. 619 S Green St. Ward

(Usual place of abode) (If non-resident give city or town and State) July

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 10 1883

7 AGE: Years 44 Months 4 Days 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Steam Boat

(c) Name of employer: Indian Head Boat Co

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Geo. Harper

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Josephine Crayton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant (Address): Lizzie McFadden 2106 S Green St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Hurley M. D. (Coroner)

7/4, 1927 (Address) 7006 Channel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.,..... mos.,..... ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct Date of Burial July 9 19 26

20 UNDERTAKER: H. N. Brown & Son ADDRESS 1111 Monroe St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23665 DEATH

REGISTERED No. E 23665

CITY OF BALTIMORE (No. St. Elizabeths' Home ... St. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alexander Brooker Jr.

(Residence in Baltimore: No. St. Elizabeths' Home St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: August (Month) 29 (Day), 1925 (Year)

7 AGE: 1 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.? 4

8 OCCUPATION
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Alexander Brooker

11 BIRTHPLACE OF FATHER (State or country): Canada

12 MAIDEN NAME OF MOTHER: Anna Jackson

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Rose

(Address) 701 Cary St.

15 Filed ..., 191 ... REGISTRAR

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 3 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1927 to July 2 1927 that I saw h— alive on July 2, 1927 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1 mos. ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Frank J. Ayd M. D.

July 3, 1927 (Address) 2005 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL: St Peters

DATE OF BURIAL: July 5, 1927

20 UNDERTAKER: Virginia C Burn

ADDRESS: 1412 N Eager

Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 23666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21-2179 E 23666

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1201 Washington Blvd (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl. Otto Kretzschmar

(a) RESIDENCE NO. 1201 Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S. If of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Kretzschmar

6 DATE OF BIRTH (month, day, and year): Nov 14 1874

7 AGE — Years: 52 — Months: 7 — Days: 18

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Karl. O Kretzschmar

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Ida Kretzschmar 1201 Washington Blvd

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

5-1927 Per L.A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1927, to July 2nd 1927, that I last saw h... alive on July 2nd 1927, and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Hampson Jones M. D.

July 4, 1927 (Address) 517 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: July 5th 1927

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 2178 B...

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is ... may be properly classified. ... should state CAUSE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23667

E 23667

CERTIFICATE OF DEATH.

REGISTERED NO. 188-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Phillips

(a) RESIDENCE NO. 1604 Aliceann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 27/22

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Phillips

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Gyza

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Phillips

(Address)

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Itracranial Hemorrhage

Acruck by automobile at 600 block S. Bond St. accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Ryan M. D.

(Coroner)

7/5/27 18 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

Date of Burial 7/5/27 19

20 UNDERTAKER F. Wojazewski

ADDRESS 1930 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23668

CERTIFICATE OF DEATH.

118-002

E 23668

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert C. Karwacki

(a) RESIDENCE NO. 1814 Bank St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter Karwacki

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER FrancesWernock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna.

14 Informant Walter Karwacki

(Address)

15 Filed..... 19 C. HARRISON JONES Registrar

JUL 5 - 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intussusception (Intestinal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. Sybert Gaines M. D.

(Coroner)

7/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial July 6/27 19

20 UNDERTAKER F W Rozanowski ADDRESS 1930 Eastern Ave

Spec.–7-17-26—A Co.—200 Bks.

E 23669

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23669

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 121 S. Broadway — St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cohen

(a) RESIDENCE NO. 121 S. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S. if of foreign birth 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) General Merchant

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abr. Cohen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Goodman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Rosa Cohen

(Address) 121 S. Broadway

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 5 — 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28 . 1927 . to July 5 — . 1927 .

that I last saw h.. alive on July 4 — . 1927 .

and that death occurred, on the date stated above, at 12 - m.

The CAUSE OF DEATH* was as follows:

Uremia - Chronic Broncho-

(duration) 6+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Coma — Cerebral Hemorrhage

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Dr. O. Brasen M. D.

7/5. 1927 (Address) 125 S. Broadway —

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial 7/8 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E. Baltimore St

JUL 5 - 1926 HAMPSON LAMB M. D.

Key important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

E 23670

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23670

CERTIFICATE OF DEATH.

114

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 W. Hoffman St. 11-24 Ward)

2-FULL NAME Ada Ross

(a) RESIDENCE NO. 411 W. Hoffman St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Ross

6 DATE OF BIRTH (month, day, and year) June 6, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Washington Ross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Rachel Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant George Ross

(Address) 411 W. Hoffman St

15 Filed JUL 5 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

1/2 hr.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ac. Gastro-enteritis. 3 hrs.

(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Kenney M. D.

(Coroner)

July 4, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial July 6 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland ave

Spec.—1-12-23—M&T—500 Bks.

E 23671 — HEALTH DEPARTMENT—CITY OF BALTIMORE — E 23671

CERTIFICATE OF DEATH.

37-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital (Street) 13-4 (WARD)

2-FULL NAME Helen Handy Ward

(a) RESIDENCE NO. 35 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Columbus Ward.

6 DATE OF BIRTH (month, day, and year) Unknown 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Benj. Tenglemann 35 S. Caroline

15 Filed ... 19 ... Registrar

E - 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1927, to July 2, 1927, that I last saw her alive on July 2, 1927, and that death occurred, on the date stated above, at 8.10 m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Hahn, M. D.

, 19 (Address) 38 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Lawn Cemetery — DATE OF BURIAL July 5, 1927

20 UNDERTAKER Mrs R.G. Ellerts — ADDRESS 1225 Ashland Ave

Per Harold

Spec.–7-17-26—A Co.—200 Bks.

E 23672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23672

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 1622

BALTIMORE CITY HOSP[illegible]

City of BALTIMORE: (No. [illegible] St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jennings

(a) RESIDENCE NO. 1510 Riggs Alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Ont

(c) Name of employer

9 BIRTHPLACE (city or town) ....

(State or country) Md.

PARENTS

10 NAME OF FATHER Gaston Stewart

11 BIRTHPLACE OF FATHER (City or town) ....

(State or country) Md.

12 MAIDEN NAME OF MOTHER Teresa ?

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Md

14 Informant BALTIMORE CITY HOSPITALS

(Address) [illegible]

15 Filed ...., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/1927

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1927, to July 2, 1927

that I last saw h[illegible] alive on July 2, 1927

and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute, chronic

Myocardial insufficiency

Arteriosclerosis

(duration) .... yrs. 1 mos. .... ds.

CONTRIBUTORY ....

(Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? General & Symptoms

(Signed) C Stevens Siegel, M. D.

, 19.... (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	July 5 1927
20 UNDERTAKER	ADDRESS
Samuel T Hemby	518 W Fred St

Instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bkn.

E 23673

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23673

118-002

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 Winter St. 13-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Parker.(C)

(a) RESIDENCE NO. 125 Winter St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. _____ How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married.

5a If married, XXXXXXXXXXXXX HUSBAND of XXXXXXXXX Mary Parker.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Junius Parker.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Martha.------(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Mary Parker.(C) wife.

(Address) 125 Winter St.

15 Filed July 5 1927 C. HAMILTON JONES, M.D. Registrar

By H. L. [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestional Obstruction.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

Signed Otto W. Pennhard M.D. (Coroner)

7/8 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Pt Auburn Cem	July 5 1927

20 UNDERTAKER	ADDRESS
Samuel T Hensley	578 W Fayette

Cor.—12-9-25—A Co.—200 Bks.

E 23674 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23674

CERTIFICATE OF DEATH. 188-002

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 18-22 Ward)

2-FULL NAME Harry Hoberman

(a) RESIDENCE NO. 1004 Vine Street St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Dec. 16th-1911

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
15	6	18	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Boy do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Sameul Hoberman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Rudman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sameul Hoberman (Father)

(Address) 1004 Vine St.

15 Filed JUL 5 1927 C. HAMPSON JONES, M. D. Registrar

By H. Hess

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th-, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dr Car Acc.

Fracture of Skull (duration) hrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock (duration) hrs. mos. 2 ds.

July 5 1927 (Signed) C. Hampson Jones (Coroner) M. D.

(Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Woodlawn Date of Burial July 5 1927

20 UNDERTAKER Jack Levin ADDRESS 143 E Biddle

Spec.-7-17-26—A Co.—200 Bks.

Joseph Cromwell

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23675

CERTIFICATE OF DEATH

45

E 23675

1-PLACE OF DEATH

REGISTERED NO. 15-61

City of BALTIMORE: (No. St. Joseph Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cromwell

(a) RESIDENCE NO. 2603 Denison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maria Cromwell.

6 DATE OF BIRTH (month, day, and year) May 5 1860

7 AGE	Years	Months	Days
	67	1	28

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent. Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Cromwell

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mary Keyser

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs Maria Cromwell

(Address) 2603 Denison st

15 Filed ....., 19 .....

JUN 5 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1927, to 7-3, 1927,

that I last saw h~~im~~ alive on 7-3, 1927,

and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

Chr. Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos 3 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 6-29-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Fahrney, M. D.

, 19 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemty.

Date of Burial July 6 1927

20 UNDERTAKER

Geneya - J. Ruth.

ADDRESS 1335 Harford ave.

Any important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23676

CERTIFICATE OF DEATH.

129 E 23676

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2510 Francis St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenora V. Stockney

(a) RESIDENCE NO. 2510 Francis St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Female. White

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE~~ of) John Stockney

6 DATE OF BIRTH (month, day, and year) Nov. 23-1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos. Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Shipley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Stockney

(Address) 2510 Francis St

15 Filed 5-1927, 19 C. HAMILTON JONES, M. D. Registrar

Per GHG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 26th 1927, to July 4th 1927,

that I last saw h~~e~~ alive on July 3rd 1927,

and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Edward E. Rulon, M. D.

(Address) 2227 N. Fulton Ave. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial July 7 1927

20 UNDERTAKER: Harry W. Ehlen ADDRESS 1944 W. Northern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23677

CERTIFICATE OF DEATH.

90 E 23677

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3115 Dillon ST. 1 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Helen Dobart

(a) RESIDENCE NO. 3115 Dillon ST. 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Albert Edward Dobart

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 637

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Seets

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Hamah F. Stevens

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Albert E. Dobart
(Address) 114 Overhill Rd.

15 Filed JUL 5 - 1927 19 C. HARRISON JONES, M. D. Registrar Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927 to July 4, 1927.

that I last saw her alive on July 2 1927.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism, following left hemiplegia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas M. D.

7-4 1927 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL July 7 1927

20 UNDERTAKER George N. Zirkler ADDRESS 1737 E. Eager st

Spec.–7-17-26—A Co.—200 Bks.

E 23678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 23678

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital

City of BALTIMORE: (No. Municipal Hos. St., 15521 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Conaway.

(a) RESIDENCE NO. 1522 Prestman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 7 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Conaway

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Daniel Conaway

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Polly Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hospital Records

(Address) Balto City Hospital

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

JUL 5 - 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 2. 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 1st. 1927. to July 2 1927.

that I last saw h alive on July 2 1927.

and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngeal

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Findings at Autopsy

(Signed) C. Holmes Brown M. D.

7/2. 1927 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial July 5 1927

20 UNDERTAKER Virginia A Brook ADDRESS 1463 Carey

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23679

100-E 23679

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 1626

City of BALTIMORE: (No. 6572 St Helena Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E Blosser

(a) RESIDENCE NO. 6572 St Helena Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. 26 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 8 th 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	8	26	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Goerge G.Blosser

11 BIRTHPLACE OF FATHER (City or town)

(State or country) W;Va.

12 MAIDEN NAME OF MOTHER Nellie Black

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Smithfield Pa.

14 Informant George G;Blosser

(Address) 6572 St Helena Ave

15 Filed ... 19 ... C. HAMPSON JONES, M.D. Registrar

Per ...

JL 5-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 5 th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30. 1927. to July 5 1927.

that I last saw her alive on July 4 1927.

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY None

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A.W.Reich, M. D.

7/5 19 27 (Address) Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Point Marion Pa	7/5/1927

20 UNDERTAKER John Welrich

ADDRESS 2007 Orleans

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23680

CERTIFICATE OF DEATH

169 E 23680

1-PLACE OF DEATH found in Harbor

City of BALTIMORE: (No. foot of Carolina St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Williams

(a) RESIDENCE NO. 1643 E Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant John Williams (Bro.)

(Address) 122 N Calvert St

15 Filed 5 1927, 19 C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jumping into Harbor

Suicide by drowning

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Hanlon M. D.
(Coroner)

July 4, 1927 (Address) 700 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred and buried in Loudon Park Mt Calvary Cem 7-3 1927

20 UNDERTAKER Bynon & Wright ADDRESS 1218 Madison Ave

Spec.—12-9-25—A Co.—200 Pks.

19398 5 — E 23681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 23681

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Brady

(a) RESIDENCE NO. 109 S. Potomac 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan

6 DATE OF BIRTH (month, day, and year): Nov. 1871

7 AGE: 55 Years: 56 Months: 8 Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pa R. R.

(b) General nature of industry, business, or establishment in which employed (or employer): 613

(c) Name of employer

9 BIRTHPLACE (city or town): Md — Balto. Co.

(State or country)

PARENTS

10 NAME OF FATHER: ~~Edward~~ ~~Allison~~ Brady

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: ~~Ann Wolfe~~ Ethie Stanton

13 BIRTHPLACE OF MOTHER (city or town): ~~Ireland~~

(State or country) Ireland

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 5 — 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1926 to July 4, 1927.

that I last saw h~~im~~ alive on July 4, 1927.

and that death occurred, on the date stated above, at 7.10 a. m.

The CAUSE OF DEATH* was as follows:

Post-mitral stenosis, obstruction, fibrosis, chronic adhesive pericarditis.

(duration) yrs. 11 mos. 17 ds.

CONTRIBUTORY (Secondary) bronchopneumonia (acute)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of June 10, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. Everett Sanger, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: July 6 1927

20 UNDERTAKER: Kelly & Zeller — ADDRESS: 403 S. Wolfe St.

Spec.—1-12-23—M&T—500 Bks.

E 23682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 23682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Luzerne ST. 7-10 WARD)

2-FULL NAME Elizabeth Huppmann

(a) RESIDENCE NO. 531 Luzerne ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Huppmann

6 DATE OF BIRTH (month, day, and year) Nov 25 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michael Kalz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Crescentia Lightner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Caspar Wagoner
(Address) 531 Luzerne ave

15 Filed JUL 5 - 1927 C. HAMPSON JONES, M. D. Registrar
Per R/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 3, 1927, that I last saw h.. alive on July 3, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure c Pulmonary oedema

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of liver

Viscera (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Blood typing

Was there an autopsy? No.

What test confirmed diagnosis? Laparotomy

(Signed) Leo J. Brown M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 6 1927
20 UNDERTAKER	ADDRESS
Wendell Eppleton	37 Lanvale

Spec.—1-12-23—M&T—500 Bks.

Blake 1014 N Lafayette

E 23683 HEALTH DEPARTMENT—CITY OF BALTIMORE

36-002

CERTIFICATE OF DEATH.

E 23683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Loudon Ave. WARD) 36-11

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Elloff

(a) RESIDENCE NO. 231 Loudon Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-6-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	17	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Albert J. Elloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary E. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Albert J. Elloff

(Address) 231 Loudon Ave

15 Filed ..... 19 ..... Registrar

1927 C. HARRISON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1 1927 to July 3 1927

that I last saw her alive on July 1 1927

and that death occurred, on the date stated above, at 6:30 a m

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary): operation for adenitis

R. Humerus (duration) ... yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of May 1 27

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Albert J. Blake, M. D.

, 19 (Address) 1014 N Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 7/6 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23684 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23684

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 16-N Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Dunfour

(a) Residence No. Nursery & Childs Hospital St. ... Ward ...
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 hrs How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 30'27

7-AGE. ...yrs. ...mos. ...ds.

If LESS than 1 day, 12 hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Oliver Dunfour

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ruth Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Ruth Dunfour

(Address) Nursery & Childs Hospital

15- Filed ... 192... 1927 C. HAMPSON GIBBES, M. D.

Per ... Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year). June 30'27

17- I HEREBY CERTIFY, That I attended deceased from June 30, 19.27 to June 30, 19.27

that I last saw her alive on June 30, 19.27

and that death occurred, on the date stated above, at 6 19/35 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Margaret B. Ballard M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westview of Md.

DATE OF BURIAL, ..., 19...

20-UNDERTAKER.

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23685

E 23685

CERTIFICATE OF DEATH

1-PLACE OF DEATH 5235 St Charles Ave. Arlington.

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. WARD

2-FULL NAME Dorathy Schalitzky

(a) RESIDENCE No. 5235 St Charles Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-30-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	39	8	2	3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Andrew Schalitzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Neahnert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Marshall

(Address) 5-23-27 5235 St Charles Ave.

15 Filed 5-25-1927 C. HARRY JONES, M. D. Registrar

By K/C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3- 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1927, to July 3 1927, that I last saw h[illegible] alive on June 27 1927, and that death occurred, on the date stated above, at 12.05 a.m.

The CAUSE OF DEATH* was as follows

Pulmonary Tuberculosis

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Special case of tuberculosis

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy? No Symptomatic

What test confirmed diagnosis?

(Signed) Henry Ackell M. D.

(Address) 3901 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL 7-6-27

20 UNDERTAKER Martin Fahey & Sons ADDRESS 182-184 North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

204 11 E 23686

CERTIFICATE OF DEATH

161-001 E 23686

1-PLACE OF DEATH Johns Hopkins Hospital

City of BALTIMORE: (No. ____ St., 35 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy James

(a) RESIDENCE NO. 911 Caton Av St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-9-27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3 Mths		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Md

PARENTS

10 NAME OF FATHER ____

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) ____

12 MAIDEN NAME OF MOTHER Willie James

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) ____

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed ____, 19 ____ 1510 RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1927, to June 30, 1927

that I last saw him alive on June 30, 1927,

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) I. Ridgeway Smith, M. D.

, 19 (Address) ____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ____ Date of Burial ____ 19

20 UNDERTAKER ____ ADDRESS ____

JOHNS HOPKINS HOSPITAL JUL 5 1927

Commissioner of Health

Spec.—1-10-21—M&T—1500 Bks.

E 23687 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-002

E 23687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST. 946 W. , WARD)

2-FULL NAME Baby Boy Parr.

(a) RESIDENCE NO. 542 E. 22nd ST., WARD

(Usual place of abode) 20 min.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Unfinished

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4 '27

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Adrian Parr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Martha Blattenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Adrian Parr.

(Address) 542 E. 22nd

15 Filed JUL 5 - 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1927

17 I HEREBY CERTIFY That I attended deceased from July 4 1927 to July 5 1927.

that I last saw him alive on July 5 1927.

and that death occurred, on the date stated above, at 12 Am.

The CAUSE OF DEATH* was as follows

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged labor, instrumental delivery (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Forbes M. D.

19 (Address) 2301 Oakfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: DATE OF BURIAL 19

20 UNDERTAKER: ADDRESS

JOHNS HOPKINS HOSPITAL Obstetrical Asstt. JUL 5 1927

Instructions on back of certificates. Statement of OCCUPA-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23688

CERTIFICATE OF DEATH.

1941

E 23688

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Sinai Hospital St. 9-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel R. Black

(a) RESIDENCE NO. 604 Stoneleigh Road St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jean Black

6 DATE OF BIRTH (month, day, and year) Nov 25/1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer Central Iron & Steel

9 BIRTHPLACE (city or town) ____

(State or country) Chicago, Ill

PARENTS

10 NAME OF FATHER John Black

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Clark

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Scotland

14 Informant Jean Black

(Address) 604 Stoneleigh Rd

15 Filed ____ 19__ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(History of "Heat Prostration" in Memphis 5 days previous)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. K. Cullen M. D.

(Coroner)

7/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill. Date of Burial July 6 19 27

20 UNDERTAKER H. Fred Jones Inc ADDRESS 1527 Pennsylvania Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23689 E 23689

CERTIFICATE OF DEATH

27-48 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Willow Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Kelly

(a) RESIDENCE NO. 508 Willow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane E. Kelly (nee Kelly)

6 DATE OF BIRTH (month, day, and year) Oct 23 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Iron Molder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daughter Mary Calahan

(Address) 508 Willow Ave

15 Filed July 7, 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 4 1927

17 I HEREBY CERTIFY, that I attended deceased from April 11, 1927 to July 4, 1927.

that I last saw him alive on June 24, 1927.

and that death occurred, on the date stated above, at 10 P— m.

The CAUSE OF DEATH* was as follows

(a) Chr. Myocarditis

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Interstit Nephritis

(Duration) 20 yrs. mos. ds.

18 Where was disease contracted (if not at place of death)? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jno R. Fraguly, M. D.

July 5 1927 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Garland Holy Cross Cemetery — DATE OF BURIAL: July 7, 1927

20 UNDERTAKER: Emmit W. Conklin — ADDRESS: 124 E Eager St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23690

161-001

CERTIFICATE OF DEATH

E 23690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 811 Rutland

CITY OF BALTIMORE: (No.) 811 Rutland ST. 9-13 WARD)

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 811 Rutland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... dt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Wilbur Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lilla Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant
(Address)

Filed ..... 19..

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1927, to July 2, 1927, that I last saw h alive on July 2, 1927, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Ex.

(Signed) Wm. Berry, M. D.

, 19 (Address) 1502 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

J 1927 1505 RK

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23691

CERTIFICATE OF DEATH.

167-001

E 23691

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 804 Reservoir St. St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Beck

(a) RESIDENCE NO 804 Reservoir St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 — 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Beck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Mallie Breyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Mrs. Wolf

(Address) 804 Reservoir St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

thereon and from the evidence obtained by said Inquest, and from the autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Self Inflicted Gunshot Wound

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison M. D.

(Coroner)

7/5, 1927 (Address) 632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. Date of Burial July 6 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23692 ✓

E 23692

179-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinia Hospital St. 27-54 Ward)

2-FULL NAME Edith Rubin

(a) RESIDENCE NO. 401 Belvedere Ave., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) March 26 -1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Rubin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Samerodin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Joseph Rubin (Father)

(Address) 401 Belvedere Ave..

15 Filed JUL 5 1927 C. HARVEY CULLEY M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over body. Clothing caught fire while using matches to light fire works. July 4/27

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Riley M. D.

(Coroner)

7/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial July 6 1927

20 UNDERTAKER Jack Levin ADDRESS 1409 E Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 23693 — 198 — REGISTERED NO. E 23693

City of BALTIMORE: (No. Colonial Hosp St. 16-22 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Belle Brent

(a) RESIDENCE NO. 1201 W Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) July 27 1927 (Address) 2502 Eutaw Pl

(State or country) Miss.

PARENTS

10 NAME OF FATHER Chas. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Moore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Miss.

14 Informant

(Address) 1201 W Baltimore St

15 Filed..... 19..... C. HARRISON JONES, M. D.

Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Multiple abscesses of Chest.

(duration) 16 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Dulaney Valley July 6 1927

20 UNDERTAKER Samuel Easton ADDRESS 516 Park Ave

Cor.—12-9-25—A Co.—200 Bks.

E 23694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 E 23694

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial House St. 16 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Mathews

(a) RESIDENCE NO. 817 W Baltimore St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ollie Mathews

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Ollie Mathews

(Address) 817 W Baltimore St

15 Filed 19 C. HARRY JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Multiple bullet wounds in back, also in right elbow.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Homicide

(duration) yrs. mos. ds.

(Signed) J. C. T. Hennessy M. D. (Coroner)

192 7 Address 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial July 6 - 1917

20 UNDERTAKER Daniel Easton & Sons ADDRESS 916

Spec.—1-12-23—M&T—500 Bks.

E 23695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 23695

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 S Broadway ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Yolken

(a) RESIDENCE No. 205 S Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Yolken

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 68 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Lintzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Lintzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mr Nathan Yolken

(Address): 205 S Broadway

15 Filed 7-5-1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to July 5, 1927, that I last saw her alive on July 5, 1927, and that death occurred, on the date stated above, at 8.05 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Chronic myocarditis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jacob Cohen M. D.

7/5, 1927 (Address) 223 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark N. J. DATE OF BURIAL: July 6 1927

20 UNDERTAKER: Jack Levis ADDRESS: 1439 Edmond

Cor.—12-9-25—A Co.—200 Bks.

E 23696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 ✓ E 23696

REGISTERED NO.

1-PLACE OF DEATH Declared dead at

City of BALTIMORE: (No. Hopkins Hospital St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Zezulinski

(a) RESIDENCE NO. 8 N. Chapel St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Zezulinski

6 DATE OF BIRTH (month, day, and year) Aug 22/1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Roller

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Zuckawski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Kazunski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frances Zuckawski P.O. 1[illegible]

(Address) 1 North Fola [illegible]

15 Filed 7/5 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism.

(Inquest to be held later)

..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Ryan M. D.

(Coroner)

7/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial July 6 1927

20 UNDERTAKER John M Weber ADDRESS 703 Bank St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23697

CERTIFICATE OF DEATH.

182 E 23697

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at the South Baltimore General Hospital 21-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna J Stephens.

(a) RESIDENCE NO. 718 McHenry St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 7, 1912.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	15	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Stanislaus Stephens.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Eva Rinkeivich.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania.

14 Informant Eva Stephens. (mother)

(Address) 718 McHenry St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Occidental drowning.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

7/5, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Marley Creek G. G. Co. Md. July 3, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOLY REDEEMER Date of Burial JULY 6 1927

20 UNDERTAKER C. B. KUCHAUSKAS ADDRESS 637 S PACA ST

7-1927

Spec.—12-9-25—A Co —200 Bks.

(Gross)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23698

CERTIFICATE OF DEATH.

101-001

E 23698

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 722 S. Hanover St. St. 22-30 Ward)

2-FULL NAME James Richard Gross

(a) RESIDENCE NO. 722 S. Hanover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Gross

6 DATE OF BIRTH (month, day, and year) May 1872 Date unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General Const.

(c) Name of employer Faine Bros. And Maigley

9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Nelson Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Aletha Mason

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co.

14 Informant Willian C. Gross (son)

(Address) 722 S. Hanover St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th. 1927 19

17

I HEREBY CERTIFY, That I attended deceased from From June 14th. 1927 July 4th. 1927

19 to 19

that I last saw him alive on July 3rd. 1927 19

and that death occurred, on the date stated above, at 7.20 a.m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Ter.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Mitral Ins. Ch. Int. Nephritis

(duration) 1 yrs. ? mos. ? ds.

18 Where was disease contracted If not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1681 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Auburn Date of Burial July 6 19 27

20 UNDERTAKER John H. Toadvine ADDRESS 1027 Hanover St

Spec.–7-17-26—A Co.—200 Bks.

23699

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-082

E 23699

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 834 S. Eutaw St. 07-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Parker

(a) RESIDENCE NO. 834 S. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. – mos. – ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Parker

6 DATE OF BIRTH (month, day, and year) Mar – 20 – 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	47	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General natore of industry, bosiness, or establishment in whieh employed (or employer)

(c) Name of employer Curtis Bay Coal Pier

9 BIRTHPLACE (city or town) Calvert Co.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Dan Parker

11 BIRTHPLACE OF FATHER (City or town) Calvert Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Lane Stinnett

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.

(State or country) Maryland

14 Informant Viola Howard

(Address) 830 S. Eutaw

15 Filed 6-1927 19 C. HAMPSON JONES, M. D. Registrar

Per Gray

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 1927, to 7/4, 1927, that I last saw him alive on 7/2, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) – yrs. 8 mos – ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dan Donaldson M. D.

(Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parker's. Cal. Co. Md. Date of Burial: July 7 1927

20 UNDERTAKER: John H. Toadvine ADDRESS 1027 Hanover Ave

Sale or use of certificates, or the publication of information derived therefrom except as authorized by the Department of Health, is prohibited. Penalty for violation, $100 fine. Section 4, Ordinance No. 1, approved March 1, 1926. Statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 23700 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23700

CERTIFICATE OF DEATH.

(25-15) 159-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Carroll ST. (25-15) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Lowman

(a) RESIDENCE NO. 421 Carroll ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Russell Lowman

11 BIRTHPLACE OF FATHER (city or town) Curtis Bay (State or country) Maryland

12 MAIDEN NAME OF MOTHER Esther Thawron

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant Elzey Thawron (Address) 421 Carroll Curtis Bay

Filed , 19 C. HAMPSON JONES, M. D. Registrar

5-1927 Reg. 5 MC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1927

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 5, 1927, that I last saw her alive on July 5, 1927, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation (Hydrocephalus & spina bifida).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Deibel, M. D.

, 19 (Address) 1122 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Church Cemetery area	July 6 1927
20 UNDERTAKER	ADDRESS
D. John F. Denny	715 Light St

Cor.—12-9-25—A Co.—200 Bks.

E 23701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23701

REGISTERED NO. 2502

1-PLACE OF DEATH

City of BALTIMORE: (No. 2485 Washington Blvd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rodney J. Kauffman

(a) RESIDENCE NO. Reading, Pa St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): March 12th 1927

7 AGE: Years — Months 3 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Reading, Pa

(State or country)

PARENTS

10 NAME OF FATHER Melvin Kauffman

11 BIRTHPLACE OF FATHER (city or town) Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Grimes

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant Ethel Grimes

(Address) 2485 Washington Blvd

15 Filed..... 19 C. HAMPSON JONES, M. D. Registrar

By L.H.G.

L 6-1027

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, or Inquiry.) thereon and from the evidence obtained by Inquest and Inquiry (Inquest, or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

Six Half hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

July 5th 1927 (Signed) Thos. B. Horton M. D.

(Coroner)

(Address) Curtis Bay, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reading Pa Date of Burial July 7 1927

20 UNDERTAKER: Mrs. Wm. H. Sheffield ADDRESS 2512 Harford

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23702

CERTIFICATE OF DEATH

49 E 23702

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp. St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo E Wheeler

(a) RESIDENCE NO. 1116 W Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 64 Years Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet Iron worker

(b) General nature of Industry, business, or establishment in which employed (or employer): Odk

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER James Wheeler

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Caught

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant: Baltimore City Hospitals

(Address) Woods

15 Filed ....., 19 ..... Registrar

JUL 6 - 1927 C. HAMPSON JONES, M.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to July 5, 1927

that I last saw him alive on July 5, 1927

and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Pneumonia -

(duration) Unknown

CONTRIBUTORY

(Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W Blumberg M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: July 7 1927

20 UNDERTAKER: John J Gibbs — ADDRESS: 1208 W Fayette

If the space for the work of certificates is insufficient for the entry of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23703

CERTIFICATE OF DEATH.

90 E 23703

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1736 N Port St. St., 8-16 Ward)

2-FULL NAME Anna E. Waldeck

(a) RESIDENCE NO. 1736 N. Port St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 54 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Waldeck

6 DATE OF BIRTH (month, day, and year): Sept 6/42

7 AGE: Years 75 | Months 10 | Days 28 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER John Zapf

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine — Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant Mrs Maurice Pritchett

(Address) 1736 N. Port St

15 Filed _____, 19 ____ C. HAMPSON JONES, M. D. Registrar

L 6 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-1-27, to 7-5-27, that I last saw h[illegible] alive on 7-5-27 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Nephritis acute

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) F. Reed Dunbar M.D.

(Address) 806 N. Mt. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Date of Burial: July 6 1927

20 UNDERTAKER: Philip Stewart ADDRESS 206 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

E 23704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 23704

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 706 Ward 9)

2-FULL NAME Harry Davis

(a) RESIDENCE NO. 2830 Fredrick Ave St. 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Davis

6 DATE OF BIRTH (month, day, and year) July 31 - 1863

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
63	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 62

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md

(State or country)

PARENTS

10 Father Edward A. Davis

11 BIRTHPLACE OF FATHER (city or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Virginia McLeod

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md

(State or country)

14 Informant Mrs. Emma Davis

(Address) 2830 Fredrick Ave

15 Filed ... 19... (HAMILTON JONES, M. D.) Registrar

... 1927 Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-7, 1927, to 7-5, 1927, that I last saw him alive on 7-5, 1927, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia & Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Path - urine

What test confirmed diagnosis?

(Signed) Frances L. Dalyglucas, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial July 1st 1927

20 UNDERTAKER H. B. Hilpert ADDRESS 850 W Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23705

CERTIFICATE OF DEATH.

E 23705

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 116 So. Schroeder St (Ward) 18-24

2-FULL NAME Margaret A. Bell

(a) RESIDENCE NO. 116 So. Schroeder St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. R. Bell.

6 DATE OF BIRTH (month, day, and year) May 23rd 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Chas. H. Pierpont

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth A. Sullivan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Benj F. Pierpont

(Address) 109 So. Schroeder St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest or Autopsy or Inquiry) thereon and from the evidence obtained by Autopsy and Inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) At once ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

July 5th 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 7/7/27

20 UNDERTAKER Henry H. Weitzel ADDRESS 1031 W Lombard St.

Spec.—1-12-23—M&T—500 Blks.

E 23706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 23706

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. 503 Belair Road St. 36-41 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Horton

(a) RESIDENCE No. 503 Belair Road St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Theresa Horton

6 DATE OF BIRTH (month, day, and year) Sept. 11-1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foundryman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Russell Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Amanda Tolson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Mrs. Theresa Horton
(Address) 503 Belair Rd. Roseburg

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20 1927, to July 3rd 1927, that I last saw h[illegible] alive on July 22 1927 and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows: Pulmonary Hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gertrude Mortensen M. D.

19 (Address) 6301 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park

DATE OF BURIAL July 6 1927

20 UNDERTAKER Harry F. Witzke

ADDRESS 531 N. Lombard St.

C. HAMPSON JONES, M.D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23707

CERTIFICATE OF DEATH.

31

E 23707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 Asbury Ave St., Blair Road 10 Ward)

2-FULL NAME Joe Patrick

(a) RESIDENCE NO. 513 N. Montford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Barbara Patrick

6 DATE OF BIRTH (month, day, and year) July 30-1890

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
36	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 209

(c) Name of employer

9 BIRTHPLACE (city or town) Georgia

(State or country)

PARENTS

10 NAME OF FATHER William Patrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Lula Coltrider

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Barbara Patrick

(Address) 27 Asbury Ave

15 Filed ....., 19..... C. HAMILTON JONES, M. D. Registrar

6-1927 For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. ....., 19 26, to July 3, 19 27

that I last saw ~~him~~ her alive on June 26, 19 27

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary chronic

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Hospital record

(Signed) Maryland State Department of Health Pauline Talbert, M. D.

, 19 (Address) 3326 Richmond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Can Date of Burial July 7 1927

20 UNDERTAKER Wm C. Hillas & Son ADDRESS 2334 Ave

Spec.—12-9-25—A Co.—200 Bks.

2044 03 E 23708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 23708

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No._____ St., JOHNS HOPKINS HOSPITAL 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Fischer

(a) RESIDENCE NO. 815 N. Wolfe St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13 - 1883

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 50

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Fischer

11 BIRTHPLACE OF FATHER (city or town) Pa —

(State or country)

12 MAIDEN NAME OF MOTHER Jane Rapp

13 BIRTHPLACE OF MOTHER (city or town) Pa —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 6 1927 19___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1927

17

I HEREBY CERTIFY, That I attended deceased from June 30 1927, to July 5 1927, that I last saw him alive on July 5 1927, and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?_____

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George E. Hartley, M. D.

7/5/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial July 7 1927

20 UNDERTAKER George W. Zibler ADDRESS 1737 E. Eager St.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162

E 23709

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 Pennsylvania Ave 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Washington

(a) Residence No. 1518 Pennsylvania Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: 7

4-COLOR OR RACE: colored.

5-~~Single~~, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of July 3, 1927

6-DATE OF BIRTH (month, day and year) July 3 1927

7-AGE. ....yrs....mos....ds.

If LESS than 1 day, 2 hrs. nr. 50 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: New born

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), 1518 Penn. Ave.

PARENTS.

10-NAME OF FATHER, Hardy Lee Washington

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Greenville N.C.

12-MAIDEN NAME OF MOTHER, Annie Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Rocky mount N.C.

14- (Informant):

(Address):

15- Filed 6-1927. 19 H. HAMPTON [illegible], M. D. Registrar.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3, 1927

17- I HEREBY CERTIFY, That I attended deceased from July 3, 1927, to July 3, 1927, that I last saw her alive on July 3, 1927, and that death occurred, on the date stated above, at 11:20 p m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ....yrs....mos....ds

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physician.

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount-W Md.

DATE OF BURIAL, ..., 19...

20-UNDERTAKER,

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

Schwinn

HEALTH DEPARTMENT—CITY OF BALTIMORE

23710 ✓ 117 E 23710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD) 47-56

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Schwinn.

(a) RESIDENCE NO. 4853 Park Heights Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schwinn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	50.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John Schwinn

(Address) 4853 Park heights Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1927, to July 5, 1927.

that I last saw her alive on July 5, 1927.

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) hyperthyroid storm

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/4/27.

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) Elizabeth Shuman, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: July 8 1927

20 UNDERTAKER: Wm. J. Pickell Sons ADDRESS: Norrist Pa

DEC 6 1927 C. HAMPTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23711

CERTIFICATE OF DEATH

49

E 23711

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer McCauley

(a) RESIDENCE NO. 678 Washington Blvd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 15 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sophia McCauley

6 DATE OF BIRTH (month, day, and year) 9-21-1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER John McCauley

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Anne ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Hospital records Mrs Sophia McCauley

(Address) 678 Washington Blvd

15 Filed JUL 6 1927 19 H. HAMILTON JONES, M. D. Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-20 1927 to 7-6-27 1927

that I last saw h / M alive on 7-6-27 19

and that death occurred on the date stated above, at 3:00 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (7-5-27)

Did an operation precede death? Yes Date of 7-6-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial July 8 1927

20 UNDERTAKER Jno J Jackson & Son — ADDRESS Balto

Duplicate of Certificate of Occupation is

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23712

CERTIFICATE OF DEATH.

11-001

E 23712

REGISTERED NO.

1-PLACE OF DEATH 4920 Harford Rd.

CITY OF BALTIMORE: No Balto. Md ST. 27-44 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur W. Crowder

(a) RESIDENCE. No 4920 Harford Rd. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19 Jan 19

7 AGE: Years 23 Months 1 Days 16 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Clerk (Drug)

(c) Name of employer: Sharp & Dohme

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Wm. S Crowder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER: Laura Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Father Loyal Crowder

(Address) 4920 Harford Road

15 Filed 6-1927 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6/23 19 27 to 7/5 19 27, that I last saw h~~e~~ alive on 7/5 19 27, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Paralytic duration 3 days mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Colley, M. D.

19 (Address) 5012 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cemetery Town or

DATE OF BURIAL: July 7 1927

20 UNDERTAKER: Frederick Loose & Sons

ADDRESS: Fullerton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23713

E 23713

CERTIFICATE OF DEATH. Walnut Park 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Herkimer & Eleventh St. 7-5-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Walz

(a) RESIDENCE NO. Herkimer & Eleventh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Walz.

6 DATE OF BIRTH (month, day, and year): Nov. 16 1850

7 AGE: Years 76 Months 7 Days 19 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): John Walz Herkimer & Eleventh St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927 to July 5 1927.

that I last saw her alive on July 5 1927.

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Valvular Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) H. Strokeffer, M. D.

July 5 1927 (Address) 2320 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz's — DATE OF BURIAL: July 8 1927

20 UNDERTAKER: Mc Mus John W. Teufel & Son — ADDRESS: 801 N. Fayette

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23714

CERTIFICATE OF DEATH.

90 E 23714

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cathedral & Monument St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Campbell

(a) RESIDENCE No. Severn Apartments Cathedral & Monument Sts WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 8, 1844

7 AGE: Years 82 Months 10 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mobile, Alabama

10 NAME OF FATHER: John A Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington, Georgia

12 MAIDEN NAME OF MOTHER: Ann E Goldthwaite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dalton, New Hampshire

Informant: Geo. A. Colston

(Address) 104 Charlesgate Road

Filed 1927 HAMPSON JONES, M. D. Registrar

Per K K

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year): July 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jun 24th, 1927, to July 4th, 1927, that I last saw h e alive on July 4th, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Myocarditis.
Insanity

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Carey B Gamble M. D.

, 19 (Address) 2 E 22 St Albans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: July 7 1927

20 UNDERTAKER: Henry W Jenkins & Co

ADDRESS: Oxford Baltimore

Spec.–7-17-26—A Co.—200 Bks.

E 23715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 23715

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3212 Walbrook ave St. 5-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Dougherty

(a) RESIDENCE NO. 3212 Walbrook Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. - ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) June 2 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child-

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER E. J. Dougherty

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Madeline Gaffney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant E J Dougherty

(Address) 3212 Walbrook ave

15 Filed ....., 19.... C. HUMPTON JONES M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1927, to July 6, 1927, that I last saw her alive on July 6, 1927, and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows: Acute Capillary bronchitis

(duration) ....yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ....yrs. mos. 2 da.

18 Where was disease contracted Home.

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no. Clinically

What test confirmed diagnosis?

(Signed) Fred B Smith M. D.

July 6, 1927 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New York City	7/7 1927

20 UNDERTAKER Harry A Withe ADDRESS 153 W Eutaw

L 6 - 1927

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23716

CERTIFICATE OF DEATH.

188-002

E 23716
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. City Hospital St., 3-4 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Stefan Pijanowski

(a) RESIDENCE NO. 327 S Bond St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1906

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Baker
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Michel Pijanowski
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland
12 MAIDEN NAME OF MOTHER Anna Warcinko
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Michael Pijanowski
(Address) 327 S Bond St

15 Filed JUL 6 1927 HAMPTON JONES, M. D. Registrar
By R.L.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma Rectum
Multiple Fractures
Contusions Abdomen
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

(Signed) G. E. Pfahler M. D.
(Coroner)
7/6 19 (Address) 1716 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Holy Rosary Cem July 8 19 27

20 UNDERTAKER — ADDRESS
John M Weber 1503 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23717

CERTIFICATE OF DEATH.

177 E 23717

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Rubanowski

(a) RESIDENCE NO. 301 S. Bond St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Rubanowski

6 DATE OF BIRTH (month, day, and year) Feb 13/1897

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	30	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionary Store

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor

(c) Name of employer

9 BIRTHPLACE (city or town) 6/6/27

(State or country) Poland

PARENTS

10 NAME OF FATHER John Rubanowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Agnes Rubanowski

(Address) 301 S Bond St

C. HAMPSON JONES, M. D.

15 Filed_____, 19_____

By_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ammonium Hydroxide Poisoning

(Taken by mistake)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Jones M. D.

(Coroner)

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial July 8 1927

20 UNDERTAKER John M Weber ADDRESS 1813 Bank St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 23718

E 23718

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 857-Park-Av. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Reid Scarff

(a) RESIDENCE NO. 857-Park-Av. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. ? mos. ? ds. How long in U. S. If of foreign birth? 73 yrs. 4 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maggie White Scarff

6 DATE OF BIRTH (month, day, and year) March-2-1854

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	73	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) (None)

(c) Name of employer (None)

9 BIRTHPLACE (city or town) Harford Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua H. Scarff

11 BIRTHPLACE OF FATHER (City or town) Harford Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Baldwin

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country) Maryland

14 Informant Mrs. Maggie White Scarff (wife)

(Address) 857-Park-Av. City.

15 Filed ..., 19... CHAMPION JONES, M. D.

By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-9-, 1927 to 7-5, 1927

that I last saw h... alive on 7-6, 1927

and that death occurred, on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-Sclerosis

Hypertension

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Woody M. D.

, 19 (Address) 1402 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer Church Cemetery, Harford Co. Md

Date of Burial July-7/27 19

20 UNDERTAKER STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 23719

CERTIFICATE OF DEATH

REGISTERED NO. E 23719

1-PLACE OF DEATH

City of BALTIMORE: (No.) 301-W-Lanvale-St. (St.) (Ward) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Camilla Donaldson Nicholson

(a) RESIDENCE NO. 301-W-Lanvale-St. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 79 yrs. 1 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Cook Nicholson

6 DATE OF BIRTH (month, day, and year) May-14-1848

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	79	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Harford Co.,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo.B.Dunkel

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Davidage

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Maryland

14 Informant Miss Rosa E.Nicholson(daughter)

(Address) 301-W-Lanvale-St., City.

15 Filed JUL 8 1927, 19 .... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 27.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 27, to July 6th, 19 27, that I last saw h.. alive on July 6th, 19 27, and that death occurred, on the date stated above, at 12:25 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 9 da.

CONTRIBUTORY (Secondary) Torsemide

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. H. Lankford M. D.

7/9, 19 27 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GreenMount Cemetery — Date of Burial July-8-27

20 UNDERTAKER P. STERRY & MOWEN COMPANY, WILLIAM F. WOODEN, Successor — ADDRESS 108 W. NORTH AVE

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23720

CERTIFICATE OF DEATH.

129 E 23720

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 625 W. Biddle St. St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Snowden

(a) RESIDENCE NO. 625 W. Biddle St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ?/ mos.? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1863 Day of mth. unknown

7 AGE: Years 64 | Months 1 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Drug Store

(c) Name of employer: Robinson Phar.

9 BIRTHPLACE (city or town)

(State or country): Laurel Md.

PARENTS

10 NAME OF FATHER: John Snowden

11 BIRTHPLACE OF FATHER (city or town)

(State or country): —f. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Leroy Ellis

(Address): 1906 Druid Hill Ave

15 Filed JUL 6 - 1927 C. H. [illegible] Registrar

By RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 4th. 1927

17

I HEREBY CERTIFY, That I attended deceased from July 2nd. 19 27, to July 4th., 19 27, that I last saw him alive on July 7th., 19 27, and that death occurred, on the date stated above, at 8. p m.

The CAUSE OF DEATH* was as follows:

Aortic in Stenosis

Ch. Int. Nephritis.

(duration) 1 yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary): Broken Comp. Cardiac

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter C. Carlson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel, Md.

Date of Burial: 6/7/1927

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

E 23721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 23721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1802 Druid Hill Ave St. 14-20 Ward)

2-FULL NAME Gladys Webb

(a) RESIDENCE NO. 1802 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17-1905

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	22	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER George Webb

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Dolly Ayers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Dudley Fitzhurst

(Address) 1802 Druid Hill Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 6

17 I HEREBY CERTIFY, That I attended deceased from April 27 1927, to July 6, 1927, that I last saw h.e. alive on July 5, 1927, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. McCard, M. D.

July 6, 1927 (Address) 2008 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bell Haven, Va. Date of Burial 7/8/1927

20 UNDERTAKER Wm. Geo. E. Holland ADDRESS 1631 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

E 23722
1-PLACE OF DEATH

E 23722
REGISTERED NO.

City of BALTIMORE: (No. St. Agnes Hospital St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher C Leonard

(a) RESIDENCE NO. 1530 Hanover St. 73 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Bertha Peage

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE: Years 64; Months —; Days —; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): A.S.K. House
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Cath Leonard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Orina Birmingham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Rev C J Leonard
(Address) 1530 Hanover St

15 Filed 6-1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-3 1927, to 7-5, 1927, that I last saw h[illegible] alive on 7-5, 1927, and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(with Coma)
(Duration of Coma is 2 days.)
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency, Last
Pulmonary Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted
If not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) O. J. Knapp, M. D.
7-5, 1927. (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial 7/8 1927

20 UNDERTAKER: ADDRESS 1918 Eight St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23723

CERTIFICATE OF DEATH.

E 23723

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 4-30 Ward)

2-FULL NAME Mary C. Hartge

(a) RESIDENCE NO. Galesville Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 12 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): November 5-1909

7 AGE: Years 17 Months 8 Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Oscar E. Hartge

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Grayson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Hospital Records

(Address)

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Rupture of Bladder

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Galesville Md Date of Burial July 9 1927

20 UNDERTAKER: J. A. Standsby ADDRESS: Galesville Md

JUL 7 - 1927 C. HERMON KELLY Registrar

Spec.—1-12-23—M&T—500 Blks.

E 23724 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23724

CERTIFICATE OF DEATH.

12-50 124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 N. Calvert ST. 17 WARD)

2-FULL NAME Harry J. McIntyre

(a) RESIDENCE NO. 2307 N. Calvert ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	51	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Secretary and Book-keeper

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Michael McIntyre

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabella Huey

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

Informant Miss Mary Bell McIntyre
(Address) 2307 N. Calvert Street

Filed 7-7-1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to July 6, 1927, that I last saw h[illegible] alive on July 5, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Parenchymatous Nephritis
Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Henry Glassman M. D.

July 6, 1927 (Address) 687 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/8 1927
20 UNDERTAKER Henry H. Mears & Son	ADDRESS 805 N. Calvert

Spec.–7-15-26–5C–400 Bks.

E 23725

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23725

CERTIFICATE OF DEATH

12

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1715 N. Chapel St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Struck

(a) RESIDENCE NO. 1715 N. Chapel St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 25 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Margaret Struck

6 DATE OF BIRTH (month, day, and year) March 11 1858

7 AGE: Years 69 Months 3 Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Maker

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER August Struck

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Anna Flarke

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs. Margaret Struck

(Address) 1715 N. Chapel St.

15 Filed JL 7 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per H. Abel

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Focus Motor Ataxia

..... (duration) 16 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Frahm, M. D.

7/6, 1927 (Address) 1823 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: July 8 1927

20 UNDERTAKER: Keney, Hoeck & Son — ADDRESS: 1301 E. Eager

Spec.—1-10-21—M&T—1500 Bks.

E 23726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23726

CERTIFICATE OF DEATH.

Anthony J. Hilscher

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2427 E. North Ave (St.) 8-16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Hilscher

(a) RESIDENCE NO. 2427 E. North Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Hilscher

6 DATE OF BIRTH (month, day, and year) Sept 17 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Burton Hilscher Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Echo-slovakia

12 MAIDEN NAME OF MOTHER Sophie Swarta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Echo-slovakia

14 Informant Sophie Hilscher
(Address) 2427 E. North Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27 1927 to July 6 1927.

that I last saw him alive on July 5 1927

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent A. Fowler M. D.

July 6 1927 (Address) 845 W. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 9 1927

20 UNDERTAKER Henry Hoech & Son — ADDRESS 1301 E. Eager St

JUL 7 - 1927 HAMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

E 23727

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23727

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1116 Wilcox ST., 10-14 (WARD)

2-FULL NAME Susanna Schaefer

(a) RESIDENCE No. 1116 Wilcox ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Schaefer

6 DATE OF BIRTH (month, day, and year) Nov. 23 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Hochadel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

Informant Mrs Michael Schaefer

(Address) 1116 Wilcox St

Filed OCT - 1927, 19 ... Registrar Hall

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to July 6, 1927

That I last saw her alive on July 5, 1927

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Luigi S. DeStefano, M. D.

6, 1927 (Address) 407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL July 9 1927

20 UNDERTAKER Henry Koch & Son

ADDRESS 301 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

E 23728

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23728

CERTIFICATE OF DEATH.

114

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Previous Ward St. 3-4 Ward)

2-FULL NAME Carrie Diggs

(a) RESIDENCE NO. 208 Bethel St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Chas. Diggs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Forbes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harriet Diggs

(Address) 208 Bethel St.

15 Filed....., 19..... Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 192 7.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acc. Gastro Enteritis

(duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D.

(Coroner)

July 6, 19 27 (Address) 702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial July 8 1927

20 UNDERTAKER J. J. P. Rochester ADDRESS 1413 Jefferson St.

Cor.—12-9-25—A Co.—200 Bks.

E 23729

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1818 N. Castle St St., 8-17 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E Lochstampfer

(a) RESIDENCE NO. 1818 N. Castle St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. E. Lochstampfer

6 DATE OF BIRTH (month, day, and year) April 10/ 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Theodore Renwer

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Newberger

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Chas. E. Lochstampfer

(Address) 1818 N. Castle St

15 Filed ...-1927 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(History of Probable Cardiac trouble attacks) (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) S H Paul M. D.

(Coroner)

7/7/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 7/9 1927

20 UNDERTAKER Brennan Cook ADDRESS 502 E Fay

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23730

185 E 23730

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 8-16 Ward)

2-FULL NAME John H. Baierlipp, Jr

(a) RESIDENCE NO. 1975 Patterson Place St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) March 23/1915

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John H. Baierlipp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Mumme

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant John H. Baierlipp M. D.

(Address) 1975 Patterson Place

15 Filed_____ 19____ By_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull at base

Accidently fell off Bridge at Herring Run & Harford Ave

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Surgical) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

7/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 7/9 1927

20 UNDERTAKER William Cook ADDRESS 502 E North

Spec.—12-9-25—A Co.—200 Blks.

204495 E 23731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-003 E 23731

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 15-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Owens

(a) RESIDENCE NO. 223 W Watts Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5-4-27

7 AGE: Years | Months: 2 | Days: ✓ | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: William Owen

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Logue

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Records

(Address) Johns Hopkins Hospital

Filed ....., 19.....

1327 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1927

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 6, 1927, that I last saw h[illegible] alive on July 6, 1927, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:-

Dysentery (organism not Known)

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Malnutrition Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Geraghty, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — Date of Burial 7/7 1927

20 UNDERTAKER: William Cook — ADDRESS 502 E North Ave

C. HAMPSON, M. D.

E 23732 HEALTH DEPARTMENT--CITY OF BALTIMORE E 23732

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No 100 E 23d St) REGISTERED No. C 129 15-65

2 FULL NAME Annie E Hoffman

(Residence in Baltimore: No. 3818 Dalrymple Ave Ward) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Single

6 DATE OF BIRTH: December (Month) 27 (Day), 1852 (Year)

7 AGE: 70 yrs. 6 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jacob Hoffman

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie R Helfrich

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George F Hoffman
(Address) 3818 Dalrymple Ave

15 G. HOWARD JONES, M. D.
Filed ..... 191 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 6 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191 ..... to July 6 1927
that I saw h er alive on July 5th 1927
and that death occurred, on the date stated above, at 7.45 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 7 yrs. — mos. — ds

Contributory (SECONDARY) Hypostatic pneumonia

(Duration) — yrs. 5 mos. — ds

(Signed) Harry S Beard M.D.
July 6 - 1927 (Address) 100 E 23d St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State Ohio yrs. 1 mos. 10 ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Friday July 8, 1927

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Eutaw Pl

Sec. 1. Exact statement of OCCUPATION should be obtained. Sec. 2. Physician must sign statement of cause of death and file certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 23733 HEALTH DEPARTMENT—CITY OF BALTIMORE

E-23733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Moore St. 11-24 WARD) 01-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara (Banks) Turner

(a) RESIDENCE NO. 415 Moore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Banks

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Worker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Coombs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alma Coombs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel Turner

(Address)

Filed JUL 7 - 1927 C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1927, to July 5, 1927.

that I last saw her alive on July 5th, 1927.

and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis Clinical

(Signed) Samuel A Bain, M. D.

, 19 (Address) 93 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 8, 1927

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 E. Lanvale St

Spec.—1-12-23—M&T—500 Bks.

E 23734 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23734

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 North Caroline ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Sollins or Zolitnitzky

(a) RESIDENCE No. 1202 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zolitnitzky Louis Sollins or

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
59	(59)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Selic Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis

(Address) 1439 E. Balto. St.

Filed 7-7-1927 C. HAMPSON JONES, M. D. Per H. A. Koerber

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th-1927

17

I HEREBY CERTIFY, That I attended deceased from April, 1918, to July 6, 1927.

that I last saw h[illegible] alive on July 6, 1927.

and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Ch. myocarditis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

7/6, 1927 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 7-7-1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto. St.

Spec. -7-17-26—A Co.—200 Bks.

E 23735 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23735

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 Gentry St. Ward 24-35)

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hauck

(a) RESIDENCE NO. 1311 Hull St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/4/27

7 AGE: Years — Months — Days 2 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Wm Hauck

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hale

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Hugh Reed

(Address)

15 Filed JUL 7 1927 C. HAMPSON JONES, M. D. Registrar

Per Hall

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/27 19

17 I HEREBY CERTIFY, That I attended deceased from 7/5/27 19 to 7/6/27 19

that I last saw h alive on 7/6/27 11 40 a m.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Hemorrhage Cerebral

Arteriosclerosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins M. D.

, 19 (Address) 1 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — Date of Burial July 7, 1927

20 UNDERTAKER E. L. Stevens — ADDRESS 410 Ford Ave

Cor.—12-9-25—A Co.—200 Bks.

E 23736

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23736

111-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1432 E. Madison 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Thompson

(a) RESIDENCE NO. 1432 E. Madison Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 8 1873

7 AGE: Years 54 Months 5 Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Flyer apt

(c) Name of employer: Castle Rd + Park Hts

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Chas. Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Rose Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Gertrude Hill Sister

(Address): 1432 E. Madison

15 Filed JUL 7 1927 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Probably Cardiac Ulcer

Allegation about 6 (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Patten M. D.

(Coroner)

7/7, 1927 (Address) 508 E. North Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem Date of Burial July 7 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1727 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

E 23737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 E 23737

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 McCulloh St. Ward 11-24)

2-FULL NAME James Keogan

(a) RESIDENCE NO. 1113 McCulloh St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

— male colored single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 640

(c) Name of employer General

9 BIRTHPLACE (city or town) Augusta

(State or country) Georgia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Thomas Roberts

(Address) 1426 Druid Hill Ave

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Dilatation of Heart 5 months

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis 1 hr.

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Sweeney M. D.

(Coroner)

Dec 9, 1927 (Address) 215 N Edwards St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. Date of Burial Dec 9 1927

20 UNDERTAKER Daniel J. Easton ADDRESS 1911 Pennsylvania Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23738 CERTIFICATE OF DEATH. 161-002 E 23738

1-PLACE OF DEATH Univ. Hosp. 4-30 Registered No.

City of BALTIMORE: (No. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Boy Green

(a) Residence No. Aberdeen Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Black

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/3/27

7-AGE, 7½ hrs

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Univ. Hosp. (State or Country),

PARENTS.

10-NAME OF FATHER, Charles Green.

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Beatrice Bee.

13-BIRTHPLACE OF MOTHER (city or town) Ga. (State or Country),

14-

(Informant).....

(Address).....

15-

Filed 192

C. HAMPTON JONES, M.D. Registrar.

7-1-1927 1513 RR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7/3/27

17- I HEREBY CERTIFY, That I attended deceased from 7/3/27, 19..., to 7/3/27, 19...,

that I last saw h~~e~~-alive on 7/3/27, 19..., and that death occurred, on the date stated above, at 9:~~00~~ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

following forceps delivery

(Duration) 7½ hrs yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Physical exam.

(Signed) Dwight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER, ADDRESS

UNIVERSITY HOSPITAL
Department of Health
JUL 7 1927
BALTIMORE, MD.

Spec.—1-12-23—M&T—500 Bls.

E 23739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 23739

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1953 Edmondson Ave. St.) 40-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert S. Woods.

(a) RESIDENCE NO. 1953 Edmondson Ave. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of— Annie R. Woods.

6 DATE OF BIRTH (month, day, and year) May.19.1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. M. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Emma Dare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Annie R. Woods

(Address) 1953 Edmondson Ave.

15 Filed L7-1927, 19 C. HAMILTON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 30, 19 26. to July 5, 19 27.

that I last saw him alive on July 5, 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 1 Year

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Revolulen, M. D.

, 19 (Address) 24 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	July 8 1927

UNDERTAKER	ADDRESS
Wm. L. Black	927 N. Broadway

Name of Undertaker to be written on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

Chas. H. Limpert

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 23740 — REGISTERED NO. E 23740

1-PLACE OF DEATH

City of BALTIMORE: (No. Md General 4-27 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Limpert

(a) RESIDENCE NO. 1947 Mulberry St

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Chas Limpert

6 DATE OF BIRTH (month, day, and year): Dec 17 1874

7 AGE — Years: 52 — Months: 6 — Days: 20 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 0 $0

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: Jno W Limpert

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Louise Schmidt

13 BIRTHPLACE OF MOTHER (City or town): Germany

(State or country)

14 Informant (Address): Hosp Records.

15 Filed 7-1927 C. HAMPTON MOORE, M. D. Registrar

Per RWK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-7-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/30/27 to 7/7/27, 19, that I last saw h[illegible] alive on 7/7/27, 19, and that death occurred, on the date stated above, at 3.40 a.m.

The CAUSE OF DEATH* was as follows: Contd (back)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 7 day

Pneumonia (3 days) Accidental yrs. mos. ds.

18 Where was disease contracted? Chest Trauma

If not at place of death? Home

Did an operation precede death? Yes Date of 7/1/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Symington, M. D.

, 19 (Address) Md General Hospital

*State the Disease causing death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial: July 9 1927

20 UNDERTAKER: Chas. H. Black — ADDRESS: 742 W Fayette

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 23741

E 23741

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 2-4 Ward)

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J Dumas Stugles

(a) RESIDENCE NO. 712 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Stugles

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) Relative City

15 Filed 7-1927 C. HAMPTON JONES, M D Registrar

Per R.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/1927.

17 I HEREBY CERTIFY, That I attended deceased from June 17 1922 to July 6 1927

that I last saw h. alive on July 6 1927

and that death occurred on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

Myocarditis (duration) ? yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Path.

(Signed) C. Holmes Boyd, M. D.

19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Patricks July 9 - 27 19

20 UNDERTAKER — ADDRESS

Orr & Stem & Son 156 Fayette

Sec. 2. Exact statement of OCCUPATION is necessary. Sec. 3. Exact CAUSE of death must be stated. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 23742

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23742

CERTIFICATE OF DEATH.

74-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1414 Fairview Ave. St. 8-16 (WARD)

2-FULL NAME Dora Mc Kesselring

(a) RESIDENCE NO. 1414 Fairview Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Fred Kesselring

6 DATE OF BIRTH (month, day, and year) April 11 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Edward Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Frederick J. Kesselring

(Address) 1414 Fairview Ave

Filed July 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1926 to July 6, 1927; that I last saw h, alive on July 5, 1927; and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH was as follows

Cerebral Thrombosis

(duration yrs. mos. ds.)

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration yrs. mos. ds.)

18 Where was disease contracted if not at place of death

Did an operation precede death Date of

Was there an autopsy

What test confirmed diagnosis

(Signed) Chas Jones, M. Dr

July 8 1927 Address 4 West Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL July 8 1927

20 UNDERTAKER Josiah Syfer

ADDRESS 760 W. Nord Ave

Spec.—12-9-25—A Co.—200 Blks.

E 23743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO. E 23743

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 665 W Mulberry St. H-25 (Ward)

2-FULL NAME Emmanuel Fields

(a) RESIDENCE NO. 665 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 28 / 1869

7 AGE	Years	Months	Days 6	IF LESS than 1 day.....hrs. or.....min.
	57	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Old Bay Line

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Washington Fields

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Lucy Fields

(Address) 665 Mulberry St

15 Filed 7 1927 19 HAMPSON JONES, M. D.

Per R K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 3 19 27, to July 4, 19 27

that I last saw h.. alive on July 4, 19 27

and that death occurred, on the date stated above, at 5-05 P m.

The CAUSE OF DEATH* was as follows:

Gangrene Lung

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Tubercular Lung

(duration) yrs. mos. 17 ds.

Is Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) B M. Hatcher, M. D.

7/6 19 27 (Address) 1111 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Yorktown Virginia — Date of Burial: 7-8-1927

20 UNDERTAKER: Mrs Thos G. Bailey — ADDRESS: 1421 Jefferson

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23744

CERTIFICATE OF DEATH

179-001

E 23744

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. St. 1019 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys M. Smith

(a) RESIDENCE NO. 2215 N. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20, 1916

7 AGE — Years: 10 — Months: 10 — Days: 16 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Walter J Smith

11 BIRTHPLACE OF FATHER (city or town) Stafford Co Va

(State or country)

12 MAIDEN NAME OF MOTHER Margaret E Hemming

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Margaret E Smith

(Address) 2215 N. Mulberry St.

15 Filed ..... 19 ..... Registrar

7-1927 C. HAMILTON JOHNSON, M. D. Per R.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fatal Accidental burns of body

(Burns)

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Pleurisy with fluid in both lungs,

(duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. J. Pearman M. D.

(Coroner)

July 7 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem Date of Burial July 8 1927

20 UNDERTAKER Chas. W. Little ADDRESS 2700 Edmondson

Spec.–7-17-26—A Co.—200 Bks.

Endler

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23745

CERTIFICATE OF DEATH

161-001

E 23745

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md Gen Hosp 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Endler

(a) RESIDENCE NO. 5366 N Fairdale Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 9

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6 1927.

7 AGE Years Months Days 1

26 hrs

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Antone Jno Endler

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Whitman

13 BIRTHPLACE OF MOTHER (City or town) Balto

(State or country)

14 Informant Hosp Records

(Address)

15 Filed ..... 19 .....

Registrar

C. CAMPEN JONES, M. D.

7-7-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 19

7/7/27

17 I HEREBY CERTIFY, That I attended deceased from 7/6/27 19 to 7/7/27 19

that I last saw h alive on 7/7/27 19

and that death occurred on the date stated above, at 2 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

Congenital Anomaly

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Jno A Compton M. D.

19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

Date of Burial July 8 1927

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. Fayette

Lot 3113

Please see instructions on back of certificates. Exact statement of OCCUPATION is necessary. CAUSE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23746 — CERTIFICATE OF DEATH — 129 E 23746

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2223 St Paul ST. 12-50 ~~WARD~~

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jane F. Stanley

(a) RESIDENCE NO. 2223 St Paul ST., ~~WARD~~

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh

5 [redacted], [redacted], Widowed, or [redacted] (write the word): Widowed

5a If married, widowed, or divorced [redacted] or) WIFE of: John Stanley

6 DATE OF BIRTH (month, day, and year): Oct 3, 1845

7 AGE — Years: 81 — Months: 9 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Benedict, Md

PARENTS

10 NAME OF FATHER: Wm Mathaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary C. Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Co.

14 Informant: Francis L. Laboccetta

(Address): St Agnes Hospital

Filed JUL 7 - 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1927 to July 7th, 1927, that I last saw her alive on July 7th, 1927, and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Interstitial Nephritis

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) Francis L. Laboccetta M. D.

19 (Address) St Agnes Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 9th 1927

20 UNDERTAKER: Frank V. Peyton — ADDRESS: 218 E Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23747

CERTIFICATE OF DEATH.

31 E 23747

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Prospect Ave St. Rosebury Ward 27-44)

2-FULL NAME Louis Weber

(a) RESIDENCE NO. 1 Prospect Ave St. Rosebury Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed, Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Clara Bates

6 DATE OF BIRTH (month, day, and year): July 17-1891

7 AGE: Years 35 | Months 11 | Days 18 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

10 NAME OF FATHER: Christian Weber

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Leppin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

PARENTS

14 Informant: Clara Weber

(Address): 1 Prospect Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1927

17 I, HENRY CERTIFY, That I attended deceased from July 2 1927 to July 5, 1927, that I last saw ... alive on June 30, 1927, and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

Pl Thrombosis Pulmonalis

(duration) abt yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pl Thrombosis

(duration) abt yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 502 N Pk Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis: Clinical & Laboratory

(Signed) H. P. Conran, M. D.

7-8-1927 (Address) 1704 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial July 8 1927.

20 UNDERTAKER: Jno C Mullendore ADDRESS 2334 Jefferson

7-7-1927 HAMILTON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23748

CERTIFICATE OF DEATH.

48

E 23748

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2405 Mc Elderry St. 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Dauses

(a) RESIDENCE NO. 2405 Mc Elderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mamie Dauses

6 DATE OF BIRTH (month, day, and year) April 11, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Katz

9 BIRTHPLACE (city or town) Balto

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Dauses

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mamie Dauses

(Address) 2405 Mc Elderry St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to July 6, 1927, that I last saw him alive on July 5, 1927 and that death occurred, on the date stated above, at 11 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Marjolin's Ulcer on side of scar due to burn at age 6

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Jan 13, 1926

Was there an autopsy? No

What test confirmed diagnosis? Pathological Findings

(Signed) Vincent V. Jaska, M. D.

, 19 (Address) 845 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial July 9 1927

20 UNDERTAKER Mrs C. Miller & Son ADDRESS 2334 E Fayette

Spec.–7-17-26—A Co.—200 Bks.

E 23749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001

E 23749

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1930-Mt.Royal-Terrace St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Wilkinson Lawton

(a) RESIDENCE NO. 1930-Mt.Royal-Terrace St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 8 ds. How long in U. S. if of foreign birth? 60 yrs. 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June-28-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	60	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Lawton

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Thomas

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant—Mr. Jos. T. Lawton (brother)

(Address) 5749-North Road., City.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Per RK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 6 27

17 I HEREBY CERTIFY, That I attended deceased from July 5, 19 27, to July 6, 19 27,

that I last saw h... alive on July 6, 19 27,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gastric Ulcer.

unknown.

(duration) ... yrs. ✓ mos. ✓ ds.

18 Where was disease contracted ✓

if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) E. Owings, M. D.

7/6, 19 27 (Address) 1703 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	July-8-27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

~~204300~~ 204300

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23750 — CERTIFICATE OF DEATH. — E 23750

x 117

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eppie Dowell

(a) RESIDENCE NO. Brooklandville Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 0 mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 Color or Race: White. 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910, December 7.

7 AGE: Years 16 Months 8 Days 0 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Father. Warrenton,

9 BIRTHPLACE (city or town) Virginia.

(State or country)

PARENTS

10 NAME OF FATHER Harold W. Dowell.

11 BIRTHPLACE OF FATHER (city or town) Warrenton

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Bertha Chancellor.

13 BIRTHPLACE OF MOTHER (city or town) Warrenton

(State or country) Virginia,

14 Informant

(Address) ~~JOHNS HOPKINS HOSPITAL~~

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar.

L 8 - 1927 Gtz

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from June 30 1927, to July 7, 1927, that I last saw h[illegible] alive on July 7, 1927, and that death occurred, on the date stated above, at 7[illegible]5 p m.

The CAUSE OF DEATH was as follows:

Appendicitis, acute, c perforation.

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Brooklandville, Md.

Did an operation precede death? yes Date of June 30 1927.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [illegible] James, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Warrington Va — Date of Burial: 7/8/27

20 UNDERTAKER: D. Joseph Abrems — ADDRESS: 221 Busy

Cor.—12-9-25—A Co.—200 Bks.

E 23751 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 182 E 23751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. Brick Yd Phila Rd & Sollers Av. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Allwyn McCann

(a) RESIDENCE NO. 608 S. 15th St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30th 1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER: Mr. John J. McCann

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Canada

12 MAIDEN NAME OF MOTHER: Estella Eastman

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Canada

14 Informant: Mr. John J. McCann
(Address) 608 S. 15th St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

Par ✓

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident
Drowning
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Asphyxia
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Hampson Jones M. D.
(Coroner)
July 7 19 27 (Address) 43 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial July 8 1927

20 UNDERTAKER: Lilly & Zeller — ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

E 23752 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23752

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 817 Power ST. 13-52 (WARD)

2-FULL NAME Clara V. Evans

(a) RESIDENCE NO. 817 Power ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (01) WIFE of Charles Evans

6 DATE OF BIRTH (month, day, and year) Feb 14-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Radley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Grace Steuer

(Address) 817 Powers St

15 Filed AUG 8 - 1927, 19... Registrar

C. HAMPSON JONES,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 7, 1927, that I last saw her alive on July 7, 1927, and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 4 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J M Wilson, M. D.

, 19 (Address) 823 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL July 9 1927

20 UNDERTAKER A S Marshall ADDRESS 3539 Ellerslie

Cor.—12-9-25—A Co.—200 Bks.

E 23753 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23753

CERTIFICATE OF DEATH.

188-007

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. W. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcelina M. Crowley

(a) RESIDENCE NO. 2037 Penna Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1861

7 AGE Years: 64 Months: 5 Days: 29

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Edwin Fowler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elmira Kemp

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Edwin C. Fowler

(Address) Keysville Md

15 Filed July 8 1927 C. HAMPSON JONES, M.D. Registrar

By D. Hanson

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) .....yrs. .....mos. .....ds.

(Signed) C. Hampson Jones M. D.

(Coroner)

July 7, 1927 (Address) 2812 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Front of 2016 Penna Ave

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: 7/8/ 1927

20 UNDERTAKER: William Cook

ADDRESS: 501 E. North

Spec.-7-17-26—A Co.—200 Bks.

E·23754

HEALTH DEPARTMENT—CITY OF BALTIMORE

109-00 E 23754

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2319 N Lanvale St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alpheus N. Hart

(a) RESIDENCE NO. 2319 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feby 25 1879

7 AGE: 48 Years 4 Months 12 Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Drug Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 425

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Alpheus N Hart Sr

11 BIRTHPLACE OF FATHER (City or town): Virginia

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Ann Hardie

13 BIRTHPLACE OF MOTHER (city or town): Howard Co

(State or country): Md

14 Informant: Emaline Cooper

(Address) 2319 N Lanvale St

15 Filed JUL 8 1927 19 C. HAMPSON JONES, M. D. Registrar

Per H. Adler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 3 1927, to July 7 1927, that I last saw h in alive on July 6 1927 and that death occurred, on the date stated above, at 7:50 a m.

The CAUSE OF DEATH* was as follows:

Streptococcus Sore throat

(duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schaub, M. D.

July 7, 1927 (Address) 701 N Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: July 9 1927

20 UNDERTAKER: John O Mitchell Sons & Co Funeral Parlors ADDRESS: 1900 Eutaw Place

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is necessary. Indefinite terms, such as "laborer," "clerk," "manufacturer," "dealer," etc., are not sufficient. Exact statement of CAUSE of death is necessary. Indefinite terms, such as "heart failure," "paralysis," "cancer," "tumor," etc., are not sufficient.

Spec.-7-17-26—A Co.—200 Bks.

E 23755

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23755

129

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1439 W. Franklin St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett J. Boulden.

(a) RESIDENCE NO 1439 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Louis A. Boulden

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse out

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Brooks

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Daisy La Comfet

(Address) 1439 W. Franklin St

15 Filed JUL 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per M. Lee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 7, 1927, that I last saw h[illegible] alive on July 6, 1927, and that death occurred, on the date stated above at 12:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, toxemia with repeated Convulsive seizures.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. [illegible] M. D.

7/7, 1927 (Address) 1429 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michaels Md. | Date of Burial July 10 1927

20 UNDERTAKER Chris. H. Johnson | ADDRESS 746 N. Caroline St.

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is properly classified. CAUSES should state CAUSE

Cor.—12-9-25—A Co.—200 Bks.

E 23756

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 23756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mollie Ingram

(a) RESIDENCE NO. 1520 Thames St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hoyt Ingram

6 DATE OF BIRTH (month, day, and year): October 22nd 1907

7 AGE: Years 19 Months 8 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Kotowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Alice Munska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Alice Kotowski

(Address) 1520 Thames St.

15 Filed ... 19... C. HAMPSON JONES, Registrar

OCT 8 - 1927 Per ... Deputy

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy at St. Agnes Hosp. (inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemia

Feb 16 15 hours

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

July 7th, 1927 (Signed) Thos. B. Horton M. D. (Coroner)

(Address) Curtis Bay, Baltimore

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial: July 9 1927

20 UNDERTAKER: J. W. Gazewski ADDRESS: 1930 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

E 23757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓ E 23757

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 45-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Berger

(a) RESIDENCE NO. 2426 Wilson Ave St. Ward.

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Berger

6 DATE OF BIRTH (month, day, and year) May 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs or ___ min.
	65	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employrr) U. R. R. Co

(r) Name of employer Balto Md

9 BIRTHPLACE (rity or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER August Berger

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs. Theresa Berger

(Address) 2426 Wilson Ave

15 Filed JUL 8 - 1927 C. HAMILTON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from May 23 1927 to July 7 1927

that I last saw h[illegible] alive on July 7 1927

and that death occurred on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows

Carcinoma of Prostate

Chr Myocarditis

(duration 4 yrs mos ds

CONTRIBUTORY (Secondary) Pneumonia Cardiac Failure

(duration yrs mos 10 ds

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 6-21-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lawrence Fahrney, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cathedral

Date of Burial 7-11-1927

20 UNDERTAKER H. C. Brannigan Sons

ADDRESS 517 N. Schroeder St

Cor.—12-9-25—A Co.—200 Bks.

E 23758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 23758

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Frank

(a) RESIDENCE NO. 857 Ostend St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About 76				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery etc.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Vermont

PARENTS

10 NAME OF FATHER Unknown (Brown)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Catherine Masters

(Address) 725 4 St. N.E. Washington D.C.

15 Filed JUL 8 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1927 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (secondary) Dilated Heart & Emphysema (duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

July 8 1927 (Address) 700 East Chase Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? 857 Ostend St

Former or usual residence 857 Ostend

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem. Date of Burial July 8th 1927

20 UNDERTAKER Arthur B. Cook ADDRESS 1005 W. Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23759

CERTIFICATE OF DEATH

45 E 23759

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret Miller-Deichmiller

(a) RESIDENCE NO. 14 W. Hamilton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Thirteen yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 8th 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Peter Deichmiller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wolff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Miss Dora Deichmiller

(Address) 14 W Hamilton Ave

15 Filed , 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7/6/27

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1927, to July 6, 1927, that I last saw her alive on July 6, 1927, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) This condition from infancy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 6/29/27

Was there an autopsy? no

What test confirmed diagnosis? X ray Clinical

(Signed) H Lawrence Fahnestock, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cem	7/8/27
20 UNDERTAKER Harry Deitzke	ADDRESS 1531 Eastland

Spec. 7-17-26—A Co.—200 Bks.

PLEASE PRINT. See instructions on back of certificates. Exact statement of OCCUPATION is properly classified. Should state CAUSE

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23760

CERTIFICATE OF DEATH

X 129

E 23760

REGISTERED NO. _____

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel C. Leonard

(a) RESIDENCE NO. Appalachia Va., St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 7 ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bridge Builder

(b) General nature of Industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Va.

PARENTS

10 NAME OF FATHER Joseph Leonard

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Bark

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va.

14 Informant _____

(Address) JOHNS HOPKINS HOSPITAL

15 Filed _____ 19 _____ Registrar _____

JUL 8 - 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30 1927 to July 7 1927.

that I last saw him alive on July 7 1927.

and that death occurred, on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) _____ yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension, Chr. Nephritis, Myocardial Insufficiency

(duration) 2 yrs. mos. 0 ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Cowie Adams M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bristol Penn — Date of Burial 7/8/27

20 UNDERTAKER Jos. Ahrens — ADDRESS 225 Broadway

Use only permanent black ink. Entries must be made in all cases where they are applicable. Omissions should state CAUSE when not properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 23761

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2029 Jefferson Av St. 6-9 Ward)

2-FULL NAME John R. Stotler

(a) RESIDENCE NO. 2029 Jefferson Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude F. Stotler

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1889

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
37	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in whirh employed (or employer) Box Factory

(c) Name of employer Kelly Box Factory

9 BIRTHPLACE (city or town)

(State or country) West Virginia

PARENTS

10 NAME OF FATHER William H. Stotler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Ida M. Myers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Virginia

14 Informant Ida M. Stotler

(Address) East Lexington W. Virginia

15 Filed 8-1927 C. HAMPSON JONES, M. Registrar

Year

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1924, to July 7, 1927, that I last saw him alive on July 7, 1927, and that death occurred, on the date stated above, at 4:25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 8 1927 (Address) 2006 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial July 9 1927

20 UNDERTAKER D. Philip Herzig ADDRESS 2516 Eutaw St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23762

CERTIFICATE OF DEATH.

112

E 23762

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 Booth St. 18-29 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Harris Williams

(a) RESIDENCE NO. 1026 Booth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Williams

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 40 Months: — Days: — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: James Williams

(Address): 1026 Booth St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

8-1927 By R.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and from my own knowledge and information, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

July 7 1927 (Signed) Thos. B. Norton M. D. (Coroner)

(Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: July 9th 1927

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor St

Spec.—1-12-23—M&T—500 Bks.

E 23763 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23763

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor St ST., 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Kennard Adams

(a) RESIDENCE NO. Silver Spring Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1927

7 AGE Years Months Days 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 0D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 704 Ensor St

PARENTS

10 NAME OF FATHER Caleb Adams.

11 BIRTHPLACE OF FATHER (city or town) Sykesville (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) Catonsville (State or country) Montgomery Co. Md.

14 Informant Caleb Adams

(Address) Silver Springs Md

15 Filed JUL 8 1927 C. HAMPSON JONES, M. D. By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to July 7, 1927, that I last saw him alive on July 7, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

Internal Spasm

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Internal Spasm

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. Kennard, M. D.

7-8, 1927 (Address) 704 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Colesville Md

DATE OF BURIAL 7-8 1927

20 UNDERTAKER Robert L Snowden.

ADDRESS Rockville

JUL 8 - 1927 C. W. SANDY NOSKEY'S

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23764

CERTIFICATE OF DEATH.

179-001

E 23764

1-PLACE OF DEATH

REGISTERED NO. 12-33

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Murr.

(a) RESIDENCE NO. 28 Poultney St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 27, 1919

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Murr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Agnes Barnes.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Agnes Murr. (mother)

(Address) 28 Poultney St.

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D., Registrar

6-8-1927 KK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned about the face and body by explosion of fire works. Occidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto R. Leonhardt M. D. (Coroner)

7/8, 1927 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? In front of 28 Poultney st. July 5, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial July 9 1927

20 UNDERTAKER Margaret E. Flynn ADDRESS 1420 Light St.

Spec.—1-10-21—M&T—1500 Bks.

E 23765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 23765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 322 Mt Holly ST. 20-71 (WARD)

2-FULL NAME Emma Olive Geisenkotter

(a) RESIDENCE NO. 322 Mt Holly ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Geisenkotter

6 DATE OF BIRTH (month, day, and year) July 21-1881

7 AGE Years 45 Months 11 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm L Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs W E Myers

(Address) 3523 Newman Ave

Filed 19 Per Registrar

C. HAMPSON JONES, M. D.

[illegible] - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan - 2, 1927, to July 7, 1927.

that I last saw her alive on July 7, 1927.

and that death occurred, on the date stated above, at 5-05 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm M Sharp, M. D.

7. 7 1927 (Address) 806 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery DATE OF BURIAL July 9th 27

20 UNDERTAKER Perkins & Sons ADDRESS 1723 W Lafayette Ave

Spec.—12-9-25—A Co.—300 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23766

CERTIFICATE OF DEATH.

161-001

E 23766

REGISTERED NO._____

1-PLACE OF DEATH Johns Hopkins Hospital

City of BALTIMORE: (No._____ St. 4-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pommell

(a) RESIDENCE NO. 725 W. Lexington St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 6 hours; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant Hospital

(Address) Johns Hopkins Hospital

15 Filed JUL 8 1927 19 1514 G. Hamilton Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 5 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1927, to July 5, 1927, that I last saw him alive on July 4, 1927, and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Ridgeway Trimble, M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23767

CERTIFICATE OF DEATH

74-001

E 23767

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 536 W Conaway St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Vincent

(a) RESIDENCE NO. 536 W Conaway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years 49 Months Days IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER Vincent

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N C

12 MAIDEN NAME OF MOTHER Caroline Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N C

14 Informant Maggie Vincent

(Address) 536 W Conaway St

15 Filed 1927 C. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to July 6, 1927, that I last saw h[illegible] alive on July 5, 1927 and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 14 ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Observation & Symptoms

(Signed) Charles D. Fenn, M. D.

July 7 1927 (Address) 702 S. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem July 9 - 1927

20 UNDERTAKER — ADDRESS

David Earlam 916 Pa Ave.

Exact statement of OCCUPATION is necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 23768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23768

REGISTERED NO. 20-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2229 Wilkens Ave. (ST.) (WARD)

2-FULL NAME Lizzie F. Schmidt.

(a) RESIDENCE No. 226 E. Wellens Ave. Philadelphia, Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed or divorced (or) WIFE of Charles G. Schmidt.

6 DATE OF BIRTH (month, day, and year) May 5, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Jung.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Kinderfater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles G. Schmidt. (husband)

(Address) 226 E. Wellens, Philadelphia, Pa.

15 Filed 8-1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to July 7, 1927,

that I last saw h e alive on July 7, 1927

and that death occurred, on the date stated above, at 7.05 p.m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Philadelphia, Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M Reinhardt, M. D.

(Address) 1017 E. Charles St. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL July 11th 1927

20 UNDERTAKER F. B. Wisehart ADDRESS 1850 W Baltimore St

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X86-002

E 23769 (26)

E 23769

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 9-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Campbell Sanders

(a) RESIDENCE NO. Charleston S. C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, ~~Widowed~~, or Divorced. (~~write this word~~): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mrs. A. Sanders

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 33 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farming Cooperage

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town): Charleston

(State or country): South Carolina

PARENTS

10 NAME OF FATHER: Paul Sanders

11 BIRTHPLACE OF FATHER (City or town)

(State or country): S. C

12 MAIDEN NAME OF MOTHER: Sarah Gibson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): S. Carolina

14 Informant: Record

(Address) JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8th 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 8, 1927,

that I last saw h[illegible] alive on July 8, 1927,

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Chronic mastoiditis -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema -

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Charleston S. C.

Did an operation precede death? Yes Date of June 2

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. Conley Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cutler SC and

Date of Burial: July 9 1927

20 UNDERTAKER: John C Mitchell

ADDRESS: Don MacEntyre Pl

Important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23770

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. C E 23770

1-PLACE OF DEATH Presbyterian Home of Maryland

CITY OF BALTIMORE: (No. 822 N Arlington ST. 16 WARD 23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Gilbert

(Residence in Baltimore: No. Presbyterian Home St.: 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, December (Month) 11 (Day), 1843 (Year)

7-AGE, 83 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Harford Co. Md.

PARENTS.

10-NAME OF FATHER, Richard Loflin

11-BIRTHPLACE OF FATHER (State or Country) Harford Co Md.

12-MAIDEN NAME OF MOTHER Adeline Courtney

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold C. Gibson

(Address) Staunton Va

15-

Filed JUL 8 - 1927, 191.. J. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 7 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1927, to July 7 1927, that I saw h[illegible] alive on July 6 1927, and that death occurred, on the date stated above, at 50 m.

The CAUSE OF DEATH* was as follows:

Ur[illegible] Acheurism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. 20 ds.

(Signed) J. M. Lampkin M. D.

July 8, 1927 (Address) 3 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Dear Creek Harmony Presbyterian church Harford Co. Md. DATE OF BURIAL, 7/9/1927

20-UNDERTAKER Charles G. Black ADDRESS 742 W. North Ave

Ref.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23771

CERTIFICATE OF DEATH.

X 45 E 23771

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

City of BALTIMORE: (No. 1 Broadway Street) (Ward) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Jones

(a) RESIDENCE NO. 916 N Market St. (Usual place of abode) St. Ward

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Lee Jones

6 DATE OF BIRTH (month, day, and year) Aug 16 1891

7 AGE: Years 35 | Months 10 | Days 22 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Walkersville

(State or country) Fred Co. Md

PARENTS

10 NAME OF FATHER Taylor Jones

11 BIRTHPLACE OF FATHER (city or town) Fred C.

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Strine

13 BIRTHPLACE OF MOTHER (city or town) Fred

(State or country) Fred Md

14 Informant Lee Jones

(Address) Frederick Md.

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMPSON JONES, M. D.

AUG 8 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 27 19 27 to July 8 19 27, that I last saw h.. alive on July 8 19 27, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Intestate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 7 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George B Buell, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

Date of Burial July 9 1927

20 UNDERTAKER Thos. F. Jones & Son

ADDRESS Inc. Frederick Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23772

E 23772

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7th. St and Second Ave (St.) Fairfield (Ward) REGISTERED NO.

If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME William Askew

(a) RESIDENCE NO. 7th Street and Second Ave (St.) Fairfield Md (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 6, 1926

7 AGE: Years 0 Months 9 Days 2 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fairfield, Maryland

PARENTS

10 NAME OF FATHER: William Askew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Virginia

12 MAIDEN NAME OF MOTHER: Mabel Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fairfield Maryland

14 Informant: James Cunningham (Address) Fairfield, Md.

15 Filed JUL 9 - 1927 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/8 1927

I HEREBY CERTIFY, That I attended deceased from 7/3/27, 19 , to 7/8/27, 19 , that I last saw h alive on 7/7/27, 19 , and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* was as follows: Congestion of Lungs

(duration) yrs mos 12 ds

CONTRIBUTORY (Secondary): Whooping Cough

duration yrs mos. 1 ds

18 Where was disease contracted if not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed: N. Altmeyer M.D.

19 Address: 341 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Mount Calvary Cem

DATE OF BURIAL: 7/9 1927

20 UNDERTAKER: John H. Toadvine

ADDRESS: 1027 Round Hill

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23773

CERTIFICATE OF DEATH.

146 E 23773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 136 W. Hill (ST.) 22-30 (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Floyd

(a) RESIDENCE NO. 136 W. Hill ST. 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs mos ds How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1889

7 AGE: Years 38 | Months 3 | Days 9 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Thomas Floyd

11 BIRTHPLACE OF FATHER (city or town) Accomac (State or country) Co. Va.

12 MAIDEN NAME OF MOTHER Mary Chandler

13 BIRTHPLACE OF MOTHER (city or town) Accomac (State or country) Co. Va

Informant Molly Floyd

(Address) 136 W Hill St

Filed JUL 5 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 7/7/1927

17 I HEREBY CERTIFY That I attended deceased from 7/2, 1927 to 7/7, 1927, that I last saw her alive on 7/7, 1927, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs mos 20 ds.

CONTRIBUTORY (Secondary) Difficult Labor

duration yrs mos. 7 ds.

18 Where was disease contracted (if not at place of death)?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Physical

Signed H. H. Bishop, M. D.

19 Address 759 Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 11 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Hanover

Spec.—1-12-23—M&T—500 Bks.

E 23774 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 23774

CERTIFICATE OF DEATH

REGISTERED NO.

If death occurred in a hospital or institution, give its NAME instead of street and number.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 117 S Chapel St. (WARD) 1-4

2-FULL NAME Rutherford Brown

(a) RESIDENCE NO. 111 S Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Brown

6 DATE OF BIRTH (month, day, and year) Nov 15, 1897

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
✓	29	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Jacob Brown

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country)

12 MAIDEN NAME OF MOTHER Josephine Young

13 BIRTHPLACE OF MOTHER (city or town) Balto md. (State or country)

14 Informant (Address) Josephine V. Maxwell (sister) 409 Ann st

15 Filed July 8 1927 C. HAMILTON JONES, M. D. Registrar

Post

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1927 to July 6, 1927.

that I last saw h. alive on July 5, 1927

and that death occurred, on the date stated above, at 3 P. m. (P. M.)

The CAUSE OF DEATH was as follows*

Thoracic Aneurism

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Cured

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

Signed R J Gosling, M. D.

7/7 1927 Address: 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 10 1927

20 UNDERTAKER Robert F Hudson ADDRESS 1515 McCulloh St

Spec.–7-17-26—A Co.—200 Bks.

E 23775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23775

CERTIFICATE OF DEATH

+119

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Maryland Gen'l Hosp St., 11-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gallion

(a) RESIDENCE NO. Aberdeen Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 7 1895

7 AGE: Years 51 Months 7 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Gallion

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Aaronson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Hospital Record (Address)

15 Filed JUL 9 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per H. A. Wise

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-9-27

17 I HEREBY CERTIFY That I attended deceased from 7-7-27 19 to 7-9-27 19

that I last saw h.. alive on 7-9-27 19

and that death occurred, on the date stated above, at 6 A.M. P. m.

The CAUSE OF DEATH* was as follows: Mesenteric Thrombosis - Gangrene of small intestine

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary): Gen'l Peritonitis - toxemia

(duration) yrs. mos 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-7-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Cemetery — Date of Burial: July 11 1927

20 UNDERTAKER: Osborne & McComas — ADDRESS: Aberdeen

Laws of certificates. ... of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 159-003 E 23776

CERTIFICATE OF DEATH

E 23776 REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital

City of BALTIMORE: (No. Caroline & Oliver St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mendel

(a) RESIDENCE NO. R.F.D. 10, Box 221. North Point Road. Sparrows Point St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 5 1927

7 AGE: Years ✓ Months Days 3 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Irwin Mendel

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Lillian Healy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Alabama

14 Informant Irwin Mendel
(Address) North Pt Road Sparrows Pt

15 Filed JUL 29 1927 C. HAWKINS JONES, M. D. Registrar
Per EKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 5 19 27 to July 6 19 27

that I last saw her alive on July 6 19 27

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital asphyxia - tracheal - opening -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) aspiration asphyxia -

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clinical.

(Signed) H. Laurence Fahney M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem. Date of Burial July 8 1927

20 UNDERTAKER Stephen Falkowski ADDRESS 1917 Aliceanna St

Spec.–12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23777

3/ E 23777

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2206 Boyer St. 13 Ward)

2-FULL NAME Margaret Stadtlander

(a) RESIDENCE NO. 2206 Boyer St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Stadtlander

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 38 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto

PARENTS

10 NAME OF FATHER Custer Hughes

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Hower

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto

14 Informant William Stadtlander

(Address) 2206 Boyer St

15 Filed 12-9 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 - 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

on the body of the person and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Pul TB.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

July (Signed) C. C. Jones M. D.

(Coroner)

27 19 (Address) 4 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. Holy Redeemer Date of Burial July 11 19 27

20 UNDERTAKER: Grant & Crockett ADDRESS: Oakland

Cor.—12-9-25—A Co.—200 Bks.

E 23778 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Ave near Transmission Line St. 26-38 Ward)

REGISTERED NO. 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James ~~Kafka~~ KAFKA

(a) RESIDENCE NO. Bowley's Lane Box 275 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kafka

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Nortrup- Franklin Ave

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Kafka

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Catherine Kafka

(Address) C. HAMPSON JONES, M.

15 Filed JUL 9 1927 19 Per H Abbe Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation-hung himself to tree inwoods on farm of H.G.Nortrup. Sulcide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Cole M. D. (Coroner)

7/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

D. Oakhill July 7 1927

20 UNDERTAKER ADDRESS

Tuck & Evans & Son 1906 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

E 23779

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23779

CERTIFICATE OF DEATH.

162

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 N. Kenwood Ave St., Ward 17)

2-FULL NAME William Barrie

(a) RESIDENCE NO. 800 N Kenwood Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7/27

7 AGE: Years ___ Months ___ Days 1 | IF LESS than 1 day hrs. 30 or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Barrie

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Babora

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Joseph Barrie
(Address) 800 N. Kenwood Ave

JUL 8 - 1927 HAMPSON JONES, M.D.

Filed _____ Per H. Aylward

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 8, 1927, that I last saw him alive on July 8, 1927, and that death occurred, on the date stated above, at 1300 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. C. Sobical, M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial: July 9 1927

20 UNDERTAKER: Frank E. Woodall & Co. — ADDRESS: 1900 Gilford

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23780

CERTIFICATE OF DEATH.

E 23780

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Presbyterian E. & T. Hospt. ST. 3-5 WARD) REGISTERED NO. C 6-0002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Sheilds Douglass.

(Residence in Baltimore: No. 80 Shipway, Dundalk St.; 10 yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	

6-DATE OF BIRTH, June 27th, 1897 (Month) (Day) (Year)

7-AGE, 30 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Skilled laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Tin shop

9-BIRTHPLACE, (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Edward Pixon Douglass

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia Pa

12-MAIDEN NAME OF MOTHER, Jemima Shinton

13-BIRTHPLACE OF MOTHER (State or Country), Landsford Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George Douglass (wife)

(Address) 80 Shipway Dundalk

15- JUL 9 - 1927 Filed, 191 Per C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 8 1927, that I saw him alive on July 8, 1927, and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(Duration) ... yrs. ... mos. 2½ ds.

CONTRIBUTORY (Secondary) Suppurative Mastoiditis

(Duration) ... yrs. 6 mos. ... ds.

(Signed) Randolph Schaumann M. D.

July 8, 1927 (Address) 2143 Hanover Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 4 ds. In the State 10 yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence 80 Shipway, Dundalk

19-PLACE OF BURIAL, OR REMOVAL, Philadelphia Pa DATE OF BURIAL, July 10, 1927

20-UNDERTAKER Hellen & Son ADDRESS 1326 Eutaw St

Cor.—12-9-25—A Co.—200 Blks.

E 23781

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23781

185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Jane Causey

(a) RESIDENCE NO. 1825 Walbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1924

7 AGE: Years 2 Months 9 Days 17

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Arthur F. Causey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Causey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mary E. Causey

(Address) 1825 Walbrook Ave

15 Filed JUL 9 - 1927, 19 C. HAMPSON JONES M.D. Registrar

By Henry Man

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.)

find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull Accidental

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Fell out of window

(duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Hampson M. D.
(Coroner)

July 9, 1927 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem Date of Burial 7/9 1927

20 UNDERTAKER: Cook ADDRESS 501 E North

Spec. 7-17-26—A Co.—200 Blks.

204 E 23782

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 23782

+11-002

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Garnish

(a) RESIDENCE NO. Hagerstown Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~White~~ Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12-1924

7 AGE: Years 2 Months 10 Days 26 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ond

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Bruce Garnish

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Helen Garnish

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 5 - 1927 Registrar C. HAMILTON JONES M.D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to July 6, 1927.

that I last saw h.e.l alive on July 6, 1927.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

B. influenza Meningitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Children's Hosp School

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L E Rothman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL: Woodmont Wash. Co Md. Date of Burial: July 11 1927

20 UNDERTAKER: Harry N. Fritzke ADDRESS: 53 Hollins

Instructions on back of certificates. Causes statement of OCCUPATION is

Spec.–7-17-26—A Co.—200-2ks.

E 23783

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23783

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] St.) 10-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Washington

(a) RESIDENCE NO. 1115 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 70 (?) Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 BALTIMORE CITY HOSPITALS

Informant

(Address) Records

15 Filed JUL 9 - 1927 C. HAMPSON JONES, M. D. Registrar

Per Kane

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1925, to July 7, 1927, that I last saw h[illegible] alive on July 7, 1927 and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic

arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Signs

(Signed) C. Hampson Jones, M. D.

[illegible] 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery. Date of Burial: July 9 1927

20 UNDERTAKER: F. E. Nelson. ADDRESS: 138 Preston.

54

Instructions on back of certificate. Every statement of OCCUPATION is

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 23784

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23784

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Park Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Wiley

(a) RESIDENCE. No. 1914 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	87	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Wiley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Newcastle, Delaware

12 MAIDEN NAME OF MOTHER Sarah Ann Morrell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Philadelphia, Pa.

14 Informant Frances Estep
(Address) 1914 Park Ave.

15 Filed JUL 9 - 1927 C. HAMPSON JONES, M.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to July 8, 1927, that I last saw h[illegible] alive on July 7, 1927, and that death occurred, on the date stated above, at 10:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Endocarditis
Senility. Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Non diabetic acidosis

(duration) — yrs. one mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer M. D.

7/8/1927 (Address) 3300 N. Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns R. C. Cemetery Waverly	July 11 1927
UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23785

CERTIFICATE OF DEATH

3 1 ✓ E 23785

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Meyers

(a) RESIDENCE NO. 326 S. Caroline st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer) 0 2 4

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Meyers

11 BIRTHPLACE OF FATHER (City or town)

(State or country) West Indies

12 MAIDEN NAME OF MOTHER Martha Beyers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed , 19

JUL 9 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 27, to July 6, 19 27,

that I last saw him alive on July 6, 19 27,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Holmes Boyd, M. D.

7-6-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. Date of Burial July 9, 1927

20 UNDERTAKER Wendell J. Klippel ADDRESS 300 E. Eden

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23786

CERTIFICATE OF DEATH.

179 E 23786

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun'l Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Brook Miller

(a) RESIDENCE NO. 1519 Bevard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Batty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Minnie Batty

(Address) 1519 Bevard St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc. Playing with matches Multiple Burns 3rd Degree

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

July 21 1923 (Signed) C. C. Wades M. D.

(Corner's) (Address) 453 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial July 9 1923

20 UNDERTAKER Samuel Ottenritter ADDRESS W. Baltimore

Spec. 1931—25—A Co.—200 Bks.

E 23787

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23787

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 14-20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John Landon

(a) RESIDENCE NO. 554 Pleasant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Landon

6 DATE OF BIRTH (month, day, and year): March 6, 1880

7 AGE: Years 47 | Months 4 | Days - | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Landon

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophie Jackson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

JUL 9 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to July 6, 1927, that I last saw him alive on July 6, 1927, and that death occurred, on the date stated above, at 5:5 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension, Uremia, cerebral Hemorrhage.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Diabetes

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B.P. 220/120 Cardiac hypertrophy

(Signed) W. Lindsay Smith, M. D.

7/6, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hope Cem. Date of Burial July 10 1927

20 UNDERTAKER Samuel Stevenson & Bro. ADDRESS 1211 E. Baltimore St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23788

CERTIFICATE OF DEATH.

90 E 23788

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1055 W Lexington St. 18-2 Ward)

2-FULL NAME Sarah Sears

(a) RESIDENCE NO. 1055 W Lexington St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Samuel Sears

6 DATE OF BIRTH (month, day, and year): May 1882

7 AGE: Years 45 | Months 7 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): D.C.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER Mattie Mercer

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant Emily B Sibley

(Address) 1055 W Lexington St

15 Filed JUL 9 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7/1927

17 I HEREBY CERTIFY, That I attended deceased from 5/18 1927, to 7/7, 1927, that I last saw h__ alive on 7/7, 1927 and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Valvular Heart Disease

(duration) ..... yrs. ..... mos. 49 ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

(Address) 1058 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Crem. Date of Burial 7/10 1927

20 UNDERTAKER: Byron & Wright ADDRESS 1218 McElderry St

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

204260 E 23789 + 124 E 23789

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

City of BALTIMORE: (No.) St., 1-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Nichols

(a) RESIDENCE NO. Timonium, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31-1860

7 AGE Years: 66 Months: 8 Days: 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James Nichols

11 BIRTHPLACE OF FATHER (City or town) (State or country) England

12 MAIDEN NAME OF MOTHER Betsey Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 10 1927, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1927 to July 9, 1927 that I last saw h[illegible] alive on 19 and that death occurred, on the data stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 6-28-27 Removal of gall bladder

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Morris Myers, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Md Date of Burial July 10 1927

20 UNDERTAKER R S Marshall ADDRESS 3539 Fallsway

L 10 1927

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23790

CERTIFICATE OF DEATH.

90

E 23790
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) U. Balto Gen Hosp (WARD) 9

2-FULL NAME Frank Bondroff

(a) RESIDENCE NO. 1816 E. Baltimore ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 1 dy. How long in U. S., if of foreign birth? 21 yrs. — mos. — dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Mattress Maker
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rumania

10 NAME OF FATHER: Leon Bondroff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rumania

12 MAIDEN NAME OF MOTHER: Fedie Fenore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rumania

Informant: Mrs Bondroff
(Address) 1816 E Balto St

Filed 7/10, 1927. Per RR. Registrar

C. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7 1927 to July 10 1927.
that I last saw [illegible] alive on July 10 1927
and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. 4 mos. dys.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 2 dys.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No Clin Exam.
What test confirmed diagnosis?

(Signed) Louis T. Levy, M. D.
7/10, 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel Rd
DATE OF BURIAL: July 10 1927

20 UNDERTAKER: Sol Levinson & Bro
ADDRESS 1127 E Balto St

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23791 — 44 — E 23791

1-PLACE OF DEATH Royal Court Apt — REGISTERED NO.

City of BALTIMORE: (No. Callow Ave & Lake Drive St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Macht

(a) RESIDENCE NO. Royal Court apt Callow ave & Lake Drive St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S. if of foreign birth 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Ellis Howard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Jacob Macht

(Address) Royal Court apt

15 Filed JUL 10 1927 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July, 19 26, to July 7, 19 27,

that I last saw her alive on July 7, 19 27,

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General condition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lutz, M. D.

July 6 1927 (Address) Temple Garden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem — Date of Burial 7/10 1927

20 UNDERTAKER Sol Kirson & Bro — ADDRESS 1127 E Baltimore St

Issues statement of OCCUPATION is on date of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23792 — 1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Bond St., 6-9 Ward)

2-FULL NAME Lena Turner

(a) RESIDENCE NO. 106 N. Bond St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

46

E 23792 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
F	C	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Albert Turner

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Raymond Turner (son)
(Address) 106 N Bond St.

Filed JUL 10 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23 1927 to July 7 1927 that I last saw h alive on July 7 1927 and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General debilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Young, M. D.

7/13 1927 (Address) 1424 Monument at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley cemetery — DATE OF BURIAL July 10 1927

20 UNDERTAKER Edward Bryson — ADDRESS 1631 orleans st

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

203 3E 23793 — 23 — E 23793

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 1336 Stockton St. Balto. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col-

5 Single, ~~Married, Widowed,~~ or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1924.

7 AGE: Years: 3 yrs Months: Days: IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Brown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md-

12 MAIDEN NAME OF MOTHER: Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1927, to July 9, 1927,

that I last saw h[illegible] alive on July 9, 1927,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. K. Thomas, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic

Date of Burial: July 11 19 27

20 UNDERTAKER: Hammel & Mayfield

ADDRESS: 1324 W. Baltimore St.

Sec. 3. Every statement of OCCUPATION is required. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23794

CERTIFICATE OF DEATH.

113 E 23794

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1209 Presstman ST., 17-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marian A Thomas

(a) RESIDENCE NO. 1213 Warchester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Jan 25 26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Louis H Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co

12 MAIDEN NAME OF MOTHER: Irene Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Blanch Thomas 1213 Warchester St

Filed 1927 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner)
192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters

DATE OF BURIAL July 11 1927

20 UNDERTAKER: Barnes & Whitehill

ADDRESS 1614 Pitcairn

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 E 23795

REGISTERED NO.

E 23795 CERTIFICATE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 1014 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Weiss

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nov. 9th 1861

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER George Frosler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Greffner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed 10 1927 19 C. HAMPSON JONES, M. D. Registrar

By RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

July 8th

17 I HEREBY CERTIFY, That I attended deceased from No record 19 , to 19 ,

that I last saw h Se alive on June 1 , 19 27

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death Date of

Was there an autopsy

What test confirmed diagnosis

(Signed) F. A. Warner, M. D.

July 8th, 1927 (Address) 1033 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial July 11 1927

20 UNDERTAKER Robt J Turner Sons ADDRESS 1414 N Broadway

Spec.—1-12-23—M&T—500 Bks.

E 23796 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4401 ~~Reisterstown Rd~~ ST., 15-58 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Solomon Sonnabaum

(a) RESIDENCE NO. 4401 Reisterstown Rd ST., WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta Sonnabaum

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Barney Sonnabaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Yetta Sonnabaum (Address) 4401 Reisterstown Rd

Filed JUL 10 1927, 19 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1927

17

I HEREBY CERTIFY, That I attended deceased from January, 1927, to July 9, 1927,

that I last saw h alive on July 8, 1927,

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis - liver

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lee, M. D.

July 9 1927 (Address) Temple Station

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Rosedale DATE OF BURIAL July 10 1927

20 UNDERTAKER Jack Leuis ADDRESS 1439 Eastern Ave

O.K. R.H.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23797

1-PLACE OF DEATH

CERTIFICATE OF DEATH

19-28 31

E 23797

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1426 Hollene ST. WARD)

2-FULL NAME JOSEPH BULOTA

(a) RESIDENCE NO. 1426 Hollens ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1885

7 AGE 42 Years – Months – Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Talor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

10 NAME OF FATHER Antany Bulota

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

Informant Adom Bulota

(Address) 1245 W Lexington St.

Filed 19 27 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 1926 to July 7 1927.

that I last saw him alive on July 7 1927

and that death occurred, on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs 11 mos ds

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical + X-ray findings

(Signed) John A. Buchness, M. D.

19 (Address) 37 S Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 11 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St

Spec.-7-17-26 A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23798 ✓ 129 E 23798

E 23798
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) Providence Hospital St. 1-29 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Brown

(a) RESIDENCE NO. 704 Calder alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Girl

(b) General nature of industry, business, or establishment in which employed (or employer) Archie Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va

(State or country)

PARENTS

10 NAME OF FATHER James Wells

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Marie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Thomas Brown

(Address) 704 Calder alley

15 Filed ..... 19 ..... Registrar

JUL 10 1927 Per KK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 7, 1927.

that I last saw h er alive on July 7, 1927.

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical signs & Lab.

(Signed) John W. Young M. D.

19 (Address) Providence Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — Date of Burial July 10 1927

20 UNDERTAKER S. W. Brown & Son — ADDRESS 501 W. Mulberry St

Please write plainly. Use ink. Be sure to answer every question. Statement of OCCUPATION is required in the case of persons 10 years of age and over. Physicians are requested to fill out carefully the Medical Certificate of Death. Undertakers are required to secure all information possible from informant. Registrars are required to refuse certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23799

CERTIFICATE OF DEATH

31 E 23799

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1624 N. Bradford St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Alms

(a) RESIDENCE NO. 1624 N. Bradford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Minnie W. Alms

6 DATE OF BIRTH (month, day, and year) Jan 14/87

7 AGE: Years 40 Months 5 Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. Ry & El. Co,

9 BIRTHPLACE (city or town)

(State or country) Wisconsin

PARENTS

10 NAME OF FATHER Alfred Alms

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Wis

12 MAIDEN NAME OF MOTHER Katherine Maxwell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Wis.

14 Informant Minnie W. Alms

(Address) 1624 N. Bradford

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

JUL 10 1927 RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 27 19

17 I HEREBY CERTIFY, That I attended deceased from about 3 mos 9 days 19 to 19

that I last saw h alive on July 8 pm 19 27.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

Bronchial Mediastinal Glands

(duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 1937 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bette Cem.

Date of Burial 7/12 19 27

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Aliceanna St

Be sure statement of OCCUPATION is full and satisfactory. Read instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23800 — 1-PLACE OF DEATH

71-001

E 23800 — REGISTERED NO.

City of BALTIMORE: (No. 6 N. Durham St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie B. Dorn

(a) RESIDENCE NO. 6 N. Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: Frank N. Dorn

6 DATE OF BIRTH (month, day, and year): Feb 17/94

7 AGE — Years: 33 — Months: 4 — Days: 21 — If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City.

PARENTS

10 NAME OF FATHER: Frederick Korn

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Christina Kahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Frank N. Dorn

(Address): 6 N. Durham St.

C. CLARK N. JONES, M. D.

15 Filed JUL 19 1927 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9/27

17 I HEREBY CERTIFY, That I attended deceased from June 27 19 27 to July 9 19 27

that I last saw h[illegible] alive on July 9 19 27

and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-meningitis

Diagnosis made by Dr. Spear at St. Joseph's Hosp.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal punctures

(Signed) L. C. Sobital, M. D.

19 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 7/12 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is necessary. Do not abbreviate. Write plainly. Do not use pencil. Avoid use of ditto marks. Underline the CAUSE which is the primary cause of death.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

34

CERTIFICATE OF DEATH

E 23801 — REGISTERED NO. E 23801

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 N. Rose St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hughes

(a) RESIDENCE NO. 37 N. Rose St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 13, 1910

7 AGE — Years: 16 — Months: 7 — Days: 25 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William J. Hughes

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Julia L. Smith

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md.

14 Informant: Mrs. Julia L. Hughes (Address) 37 N. Rose St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 1927, to July 6 1927, that I last saw h— alive on July 6 1927, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Ostaitis of Cervical Spine

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Subacute Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

July 8 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: 7/10/27 19

20 UNDERTAKER: Philip Haug — ADDRESS 2116 Eutaw St.

...ificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23802

CERTIFICATE OF DEATH.

× 57 E 23802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital STA. 14-26 WARD)

2-FULL NAME Alex Douglas Harrower

(a) RESIDENCE NO. 1008 Bolton + Allegheny St. E. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Elizabeth Harrower

6 DATE OF BIRTH (month, day, and year) Oct 5 1883

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	43 yr.	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER A. L. Harrower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary V. Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington Va.

14 Informant Mrs. Wm. H. Harrower

(Address) 1008 Bolton St. City

15 Filed July 12 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1927

I HEREBY CERTIFY, That I attended deceased from July 7 1927 to July 9 1927,

that I last saw h alive on July 9 1927

and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes, Hydrops of Gall Bladder (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Sherman M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park, Balto. DATE OF BURIAL July 12 1927

20 UNDERTAKER C. Carson Kennard ADDRESS 723 N. Eutaw St.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2042 E 23803 — +65-001 — E 23803

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Lovett

(a) RESIDENCE NO. 136 Arlside Dr. Newark Ward N. J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~: Rose Stone

married

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 36 — Months — Days — IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Bernard Lovett

11 BIRTHPLACE OF FATHER (City or town)
(State or country) N York

12 MAIDEN NAME OF MOTHER Kate Reiss

13 BIRTHPLACE OF MOTHER (city or town) N. York
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ___, 19__ C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 27.

17 I HEREBY CERTIFY, That I attended deceased from June 15. 1927. to July 10. 1927.

that I last saw him alive on July 10. 1927.

and that death occurred, on the date stated above, at 5:24 A. m.

The CAUSE OF DEATH* was as follows:

(a) Myeloid Leukemia

Bronchopneumonia

Angina, pharyngitis, tonsilitis & [illegible]

(duration) — yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) nephritis & hypertension

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Conley Andrus jr. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York — Date of Burial: 7/10/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Broadway

Statement of OCCUPATION is on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23804 — REGISTERED NO. E 23804

159-002

1-PLACE OF DEATH

City of BALTIMORE (No. 132 E. Ostend St. St. 2433 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vivian Sparkes.

(a) RESIDENCE NO. 132 E. Ostend St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) May 14, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Earl Tollepen.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Washington, D. C.

12 ~~XXXXX~~ NAME OF MOTHER Myrtle Sparks.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Myrtle Sparkes. (mother)

(Address) 132 E. Ostend St.

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

7/9 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial July 11 1927.

20 UNDERTAKER J. F. McCaulley — ADDRESS 148 E. Front

JUL 12 1927 — R.K.

Spec.–7-17-26—A Co.—200 Bks.

E 23805 HEALTH DEPARTMENT—CITY OF BALTIMORE 122-007 E 23805

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E Walsh

(a) RESIDENCE NO. 2407 E Fairmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos da How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John P Walsh

6 DATE OF BIRTH (month, day, and year): June 4, 1860

7 AGE: Years 67 Months 1 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maternity Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): General Practice

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country): USA

PARENTS

10 NAME OF FATHER: Daniel Dougherty

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Ann Carr

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Wm. Walsh (Son)

(Address): 309 S Curtis St

15 Filed JUL 10 1927 19 C. HAMPSON JONES, M. D. Registrar

For R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 4 19 27 to July 6 19 27

that I last saw her alive on July 6 19 27

and that death occurred, on the date stated above, at 11 45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(antecedent)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Powerful hypertension)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas Bonnick M. D.

7/7 19 27 (Address) 4 W 6 Hoffman Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick's Cem. Date of Burial 7/11 1927

20 UNDERTAKER: J. A. Moran ADDRESS 300 E Balto St.

Fill in all items. Any physician having knowledge of the facts may sign the CAUSE OF DEATH. Exact statement of OCCUPATION is necessary. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Meeks

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

E 23806

CERTIFICATE OF DEATH.

E 23806

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 205 Broad Cov 27-56 Ward)

2-FULL NAME Christian Ferdinand Meeks

(a) RESIDENCE NO. 205 Broad Cov St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Meeks

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1885

7 AGE

Years	Months	Days	IF LESS than 1 day.... hrs. or....min.
41	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamfitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry H Meeks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Egger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mary E Meeks

(Address) 205 Broad Ave

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1927, to July 8th, 1927, that I last saw him alive on July 8th, 1927, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) — yrs. 8 mos. ds.

CONTRIBUTORY (secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital

(Signed) H. R. Lucas, M. D.

7/9, 1927 (Address) 3921 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

Date of Burial 7/11 1927

20 UNDERTAKER Wellman Cook

ADDRESS Sole Wash

JUL 11 1927 C. HAMILTON JONES, M.D. Registrar

For GKG

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23807

CERTIFICATE OF DEATH.

1857 E 23807

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mer Co Hospital St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Maloney

(a) RESIDENCE NO. ~~345~~ N. Exeter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 307 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1857

7 AGE: Years 69 Months 11 Days ~~65~~ 67 y.7.d. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Jno Moylan

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: A. M.C. Farnell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: J. Moylan

(Address) 538 N Calvert

Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. R. Base of Skull accidentally fell from porch

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

July 10, 1927 (Signed) W. L. Lee M. D.

(Coroner)

(Address) 1022 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death about 36 hours yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

Date of Burial: 7/11 1927

20 UNDERTAKER: Wm Cook

ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

E 23808

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 W. Mc Mechen ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Tormey

(a) RESIDENCE NO. 120 W. Mc Mechen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Sallie H. Tormey

6 DATE OF BIRTH (month, day, and year): Jan 1-1870

7 AGE: 57

Years	Months	Days	If LESS than 1 day, hrs or min.
56	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Wright Stone Corporation

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James E. Tormey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sallie H. Tormey

(Address) 120 W. Mc Mechen St

15 Filed JUL 11 1927, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 9, 1927, that I last saw h[illegible] alive on July 8, 1927, and that death occurred, on the date stated above, at 5P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan H. Shpritz, M. D.

, 19 (Address) 1830 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 7/12 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

Spec.—1-12-23—M&T—500 Bks.

Form 904 ★ Lumbard ✓

E 23809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 23809

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Hillsdale ST., 19-28 WARD)

2-FULL NAME Charles C. Hewett

(a) RESIDENCE NO. 1607 Hillsdale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna F.

6 DATE OF BIRTH (month, day, and year) Jan 2 1861

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs or .. min.
	66	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Cowen House

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Charles C. Hewett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charlotta Linz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Anna Hewett
(Address) 1604 Hillsdale

15 Filed JUL 11 1928 ..... 19.. Registrar E. HARRISON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1928

17 I HEREBY CERTIFY, That I attended deceased from 7/4/28, to 7/7/28, 19..., that I last saw h— alive on 7/7/28, 19..., and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) — yrs mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegy

(duration) yrs mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Bernard J. Fenny, M. D.

7/9, 1928 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1928

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Monument

Richard Shakespeare

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23810

CERTIFICATE OF DEATH

74-001

E 23810

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2617 Boone St St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Shakespeare

(a) RESIDENCE NO. 2617 Boone St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jannie Shakespeare

6 DATE OF BIRTH (month, day, and year): May 3rd. 1867

7 AGE: Years 60 Months 2 Days 5

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Caroline Co

(State or country): Va.

PARENTS

10 NAME OF FATHER: Beverly Shakespeare

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Adaline Hoppin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Hannah Shakespeare

(Address) 2617 Boone St

15 Filed 7/11 1927 C. HAMILTON JONES M. D. Registrar

By Etty

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 19 27, to July 7th, 19 27, that I last saw h— alive on July 7th, 19 27, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 4 yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 3 yrs. mos ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Hunfordy 0111 E M. D.

19 (Address) 40 E 25 St

7/8/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fair view Cemetery — Date of Burial: July 11 1927

20 UNDERTAKER: Mrs. P. G. Elliott — ADDRESS: 1225 Hartland

Directions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23811 E 23811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Annapolis Road & Chesapeake ST. WARD)

REGISTERED NO. 9532

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Meldau

(a) RESIDENCE NO. Annapolis Road Westport ST. & Chesapeake WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Meldau

6 DATE OF BIRTH (month, day, and year) Nov 16 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work pipe fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER August Meldau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Tiggel Hoar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

Informant Anna Meldau

(Address) Westport

Filed JUL 11 1927 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927 to July 8 1927, that I last saw him alive on July 8 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) — yrs. 2½ mos — ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Vomiting & Hemoglobin

(Signed) Raymond Adams M. D.

July 7 1927 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Carnal — DATE OF BURIAL July 12 1927

20 UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard

Spec.—1-12-23—M&T—500 Bks.

E 23812 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 23812

1-PLACE OF DEATH 3328 Old Frederick Road REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Virginia Keaton

(a) RESIDENCE NO. 3328 Old Frederick Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Keaton

6 DATE OF BIRTH (month, day, and year) July 9th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	74	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Robert Vaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Virginia Atlas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Mrs Roy

(Address) 3328 Old Frederick Rd

Filed 11 1927, 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1926 to July 8, 1927

that I last saw h e alive on July 8, 1927

and that death occurred, on the date stated above, at 3 30 P m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl. & Phy.

(Signed) Fred J. Kyser, M. D.

, 19 (Address) 3321 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL July 11 1927

20 UNDERTAKER Thos J Fields — ADDRESS 1200 W Lombard St

Cor.—12-9-25—A Co.—200 Bks.

Bessie R French

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23813

CERTIFICATE OF DEATH.

90

E 23813

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 323 - Colvin St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie R. French

(a) RESIDENCE NO. 325 - Colvin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE: Years 35 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Worked in Store

(b) General nature of industry, business, or establishment in which employed (or employer): Rag store

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Alice Palmer

(Address) 321 Colvin St

15 Filed ..... 19..... Registrar

C. HAMILTON JONES, M. D.

JUL 11 1927 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uter. Edema

Caused by Pulmonary Cardiac Arrest

and was (duration) primary yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

and was (duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

July 10, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashby Cemetery Date of Burial: July 12 1927

20 UNDERTAKER: Chas H. Johnson ADDRESS: 620 N. Carolina St.

Cor.—12-9-25—A Co.—200 Bks.

E 23814

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3500 Elliott St., 26 Ward)

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Schenck

(a) RESIDENCE NO. 35 Elliott St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Schenck

6 DATE OF BIRTH (month, day, and year): Oct 1. 1878

7 AGE: Years 48 (47) Months 9 (7) Days 2 (28) If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Common

(c) Name of employer: City Hospitals

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: George Schenck

11 BIRTHPLACE OF FATHER (city or town): Balto City

(State or country)

12 MAIDEN NAME OF MOTHER: Veronica Wemberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: George C. Schenck Jr.

(Address): 1008 S 3d St

15 Filed JUL 11 1927 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, Autopsy or Inquiry.

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) ... yrs. ... mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) James M. Rawlins M. D.

(Coroner)

July 9 1927 (Address) 709 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery Date of Burial: June 11 1927

20 UNDERTAKER: D. Lilly & Sons ADDRESS: 1038 S. Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

E 23815 HEALTH DEPARTMENT—CITY OF BALTIMORE

148 E 23815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 76-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth S. Amend

(a) RESIDENCE NO. 3230 Fait Ave St. 20 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Amend

6 DATE OF BIRTH (month, day, and year) Nov 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
33	34	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Doughtery

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Wm J. Amend

(Address)

15 Filed 7/11/27, 19 C. HAMILTON JONES, Registrar

D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Eclampsia- (child birth) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obesity-Probable (duration) yrs. mos. ds.

(Signed) J. H. Ellis M. D.

(Coroner)

7/11/27 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemt. Date of Burial June 11 1927

20 UNDERTAKER Hamilton Lilly Zeiler Co ADDRESS 4035 Wash Blvd

Issue statement of OCCUPATION is.

Read instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 23816

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23816

CERTIFICATE OF DEATH.

168

1-PLACE OF DEATH

City of BALTIMORE: (No. 4705 Millison St. 28-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy D. Ruark

(a) RESIDENCE NO 4705 Millison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose E. Ruark

6 DATE OF BIRTH (month, day, and year) Sept 20 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	31	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER William J. Ruark

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Avey

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Rose E. Ruark

(Address) 4705 Millison St

15 Filed JUL 11 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

find that said deceased came to death (autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strangulation

Hung self

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

July 10 1927 (Signed) Thos. B. Horton M. D.

(Coroner)

(Address) Curtis Bay Balto, Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial July 12 1927

UNDERTAKER George J. Smith ADDRESS 153 Holbrook

Spec.—1-12-23—M&T—500 Blks.

E 23817 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 23817

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 2813 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O. Clarke

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) [illegible] 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
✓	56	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Keeping Books

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Georgetown D.C.

PARENTS

10 NAME OF FATHER Stephen J. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ella E. Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Christiana Del.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed JUL 11 1927 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1927, to July 10th, 1927, that I last saw h[illegible] alive on July 9th, 1927, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Praecox

abt (duration) 8 or 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

abt (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

July 10th, 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL July 12 1927

UNDERTAKER George J. Smith — ADDRESS 932 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

E 23818 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23818

CERTIFICATE OF DEATH.

REGISTERED NO. C 16-2290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Harlem Ave ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maude C Eggleston

(Residence in Baltimore: No. 1928 Harlem Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-(SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, July (Month) 9 (Day), 1860 (Year)

7-AGE, 67 yrs. 7 mos. 2 ds.

If LESS than 1 day, ...Hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Woodstock, Va.

PARENTS.

10-NAME OF FATHER, John Clinedinst

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Martha Ann Heroff

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvie W. Clinedinst

(Address) Catlett, Va.

JUL 11 1927 C. HAMPSON JONES, M. D.

Filed ....., 191.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 11th (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12th 1926, to July 11th 1927, that I saw h[illegible] alive on July 10th 1927, and that death occurred, on the date stated above, at 5.45 Am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 8 ds.

(Signed) Edw. Thomas M. D.

July 11th, 1927 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodstock Va — DATE OF BURIAL, July 13, 1927

20-UNDERTAKER George J. Smith — ADDRESS 153 E Hollins

Spec.-7-17-26—A 20.—200 Bks.

E 23819

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23819

146

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

City of BALTIMORE: (No. Caroline & Aliceana St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Fort.

(a) RESIDENCE NO. 209 S Ann St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 11 mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Fort.

6 DATE OF BIRTH (month, day, and year) Aug 1 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	19	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frederick G. Panzer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Martha Bowers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Frederick G. Panzer

(Address) 209 S Ann St.

Filed JUL 11 1927 H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 19 27 to July 10, 19 27.

that I last saw her alive on July 10, 19 27.

and that death occurred, on the date stated above, at 4:35 p. m.

The CAUSE OF DEATH* was as follows:

Pelvic Cellulitis

Septicemia (Puerperal)

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation.

(duration) yrs. mos 1 ds.

18 Where was disease contracted

if not at place of death* at home.

Did an operation precede death* No Date of —

Was there an autopsy? none

What test confirmed diagnosis? Clinical.

(Signed) H Lawrence Zahniser M. D.

19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	July 14 1927
20 UNDERTAKER	ADDRESS
Harry Klumpert	4202 Ridgewood Ave

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is property classified. CAUSES should state CAUSE

Spec.—1-12-23—M&T—500 Bks.

E-23820 HEALTH DEPARTMENT—CITY OF BALTIMORE E-23820

161-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Clifton Ave) (St.) 13-54 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fear

(a) RESIDENCE NO. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-8-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Fear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mildred Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Mildred Fear

(Address) 260 [illegible]

15 Filed 7-27, 19 By Registrar

1518

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-8 .19 27. to 7-8- .19 27.

that I last saw him alive on 7-8- .19 27

and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey M. D.

. 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

E 23821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 23821

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7135 Durham St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lewandowska

(a) RESIDENCE NO. 7135 Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Lewandowski.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Andrew Kwasniewski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Joseph Lewandowska

(Address) 7135 Durham St.

15 Filed ....., 19 .....

11 1927 C. HAMPSON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 8, 1927.

that I last saw her alive on July 8, 1927.

and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? C. S. & S. Lab.

(Signed) John L. Segerbrecken, M. D.

. 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus.	July 12 1927.
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann St.

Be important. See instructions on back of certificates. Exact statement of OCCUPATION is property classified. Cause should state CAUSE

Spec.—12-9-25—A Co.—200 Bks.

E 23822

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23822

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Schuster

(a) RESIDENCE NO. Sinai Hospital St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 7, 1927

7 AGE: Years ____ Months ____ Days 5 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Max Schuster

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Kamerow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md

14 Informant Hospital

(Address)

15 Filed _____, 19____ C. HAMPSON JONES Registrar

7 11 1927 Ham

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 July 11-1927

17 I HEREBY CERTIFY, That I attended deceased from 7-7-27, 19____, to 7-11-27, 19____, that I last saw h____ alive on 7:20 a m, 19 27, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the New-born

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) William Schuman, M. D.

7/11, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Memorial — Date of Burial 7/11 1927

20 UNDERTAKER: Jack Lauris — ADDRESS 1139 E Balt

Spec.—1-12-23—M&T—500 Bks.

E 23823 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23823

CERTIFICATE OF DEATH.

94-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew aged Home ST. 5-6 (WARD)

2-FULL NAME Gideli Weinberg

(a) RESIDENCE NO. 115 aisquith st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 110 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old aged

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant Sam Glick (Address) 702 Eutaw st

15 Filed JUL 11 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1927

17 I HEREBY CERTIFY That I attended deceased from July 8th 1927 to July 11th 1927

that I last saw h[illegible] alive on July 10 1927

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis L. Lehmer M. D.

7-11 1927 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Israel Rood — DATE OF BURIAL: July 11 1927

20 UNDERTAKER: Jack Levin 1439 Eutaw — ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23824 (1)

E 23824

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1241 N. Broadway St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Airey

(a) RESIDENCE NO. 1241 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Joseph E Airey

6 DATE OF BIRTH (month, day, and year): Nov - 1871

7 AGE: Years 56 Months 8 Days IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Hogan

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Whelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Hogan

(Address) 1241 N. Broadway

15 Filed JUL 11 1927 19 C. HAMPSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927 to July 9, 1927, that I last saw her alive on July 7 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis acute Uremia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Laboratory

(Signed) W. F. Thomas, M. D.

July 10 1927 (Address) 1228 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: July 13 1927

20 UNDERTAKER: Robt G Turner — ADDRESS: 1442 N Broadway

IMPORTANT.—Physicians should state CAUSE of death in such terms that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Libel

E 23825

CERTIFICATE OF DEATH.

E 23825

31 Brooklyn 25-53

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 401 Maryland Ave (or other street and number) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Burns

(a) RESIDENCE NO. 401 Maryland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm G Burns

6 DATE OF BIRTH (month, day, and year) Nov VI 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Harry C Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U S A

12 MAIDEN NAME OF MOTHER Alice V Lukenbach

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Wm C Burns

(Address) 401 Maryland Ave

15 Filed JUL 11 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10 1927

17 I HEREBY CERTIFY, That I attended deceased from October 15th 1925 to July 10th 1927, that I last saw h 25 alive on July 9th 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 8 mos. 25 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No tion

What test confirmed diagnosis? Sputum & Physical examination

Signed [illegible], M. D.

July 11 1927 (Address) 1224 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Date of Burial 7/12 1927

20 UNDERTAKER J J Stakeyfoos ADDRESS 1318 Eight

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23826

CERTIFICATE OF DEATH

90

E 23826

1-PLACE OF DEATH

REGISTERED NO.

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 5 [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. O'Connor

(a) RESIDENCE NO. 25 N [illegible] St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 64 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed JUL 11 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/1927

17 I HEREBY CERTIFY, That I attended deceased from June 28 1927, to July 6, 1927, that I last saw h[illegible] alive on July 6, 1927, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) hypertrophy, chronic

duration ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Symptoms

(Signed) C. Holmes Smyth M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

Date of Burial: 7/11 1927

20 UNDERTAKER: J. Fahey Sons

ADDRESS: 1318 Eutaw St

Post

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23827

CERTIFICATE OF DEATH.

181-802 E 23827

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp 14-20 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresia Valenzia

(a) RESIDENCE NO. 625 Lowell St St. Ward

(Usual place of abode) Lowell St (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 17/919

7 AGE: Years 8 Months 1 Days 22. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Balto Co

PARENTS

10 NAME OF FATHER Andrew Valenzia

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Theresia Valenzia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Andrew Valenzia

(Address) 625 Lowell St.

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

JUL 11 1927 By M M

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fire Burns Lung Pneumonia (Bronchial Lung)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

July 1 (Signed) E. T. Riley M. D.

(Coroner)

19 (Address) 657 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem Date of Burial July 12 1927

20 UNDERTAKER: Lewis Carson ADDRESS 916 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23828

CERTIFICATE OF DEATH

197 E 23828

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Penitentiary St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred A. Walker

(a) RESIDENCE NO. 1906 Homewood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 - 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Guard

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER W. C. Walker

11 BIRTHPLACE OF FATHER (city or town): N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER M. J. Corbitt

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mrs. A. Maddox

(Address) 906 Homewood

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Shot in chest and gun shot wound of chest

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Fahey M. D.

(Coroner)

July 18 1924 (Address) 1689 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. 4 days ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Date of Burial 7/12 1924

20 UNDERTAKER: J. J. Moran ADDRESS 3000 E. Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23829

CERTIFICATE OF DEATH.

90 ✓ E 23829

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 W. Cross St. St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Walden. (C)

(a) RESIDENCE NO. 421 W. Cross St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. ------- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced, (write the word) XXXXXXXXXXXX (or) WIFE of John Walden. (C)

6 DATE OF BIRTH (month, day, and year) Do not know. 190

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant John Walden. (C) husband.

(Address) 421 W. Cross St.

15 Filed 19 C. HAMPSON BOYLES, M. D. Registrar

7 11 1927 By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D. (Coroner)

7/11 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Suffolk Va Date of Burial July 11 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23830

29-001

E 23830

CERTIFICATE OF DEATH

REGISTERED NO. 9-46

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 34th & Calvert St St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl W. Schuchardt

(a) RESIDENCE NO. 2780 Tivoly Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	12	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Carl A Schuchardt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Weaver

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs Carl A Schuchardt

(Address) 2780 Tivoly Ave Balto.

15 Filed JUL 11 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5 1927 to July 9 1927

that I last saw him alive on July 9 1927

and that death occurred, on the date stated above, at 6:22 P m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus following

Infected Contusion Wound (Scalp) of

Palmar surface of R hand accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home

If not at place of death? 2780 Tivoly Ave City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History & Course

(Signed) James Collins Crumb M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Western cem July 12 1927

20 UNDERTAKER — ADDRESS

John C. Miller 2435 E Oliver St

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is property classified. Cause should state CAUSE

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23831

CERTIFICATE OF DEATH

31 E 23831

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 15B Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Baker

(a) RESIDENCE NO. 1134 Low st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Lizzie Cooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant Hospital Records

(Address)

15 Filed JUL 11 1927 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 2, 19 27, to July 6, 19 27,

that I last saw him alive on July 6, 19 27,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

unknown (duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) C. Holmes Bond, M. D.

7-6-, 1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Calvary Cem	7/11 1927

20 UNDERTAKER Byron Wright ADDRESS 1218 McCulloh St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is necessary. Also the CAUSE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23832

CERTIFICATE OF DEATH.

161-002

E 23832

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Johns Hopkins Hospital ST. 5-8 WARD)

2-FULL NAME Daisy Hampton

(a) RESIDENCE No. 517 N Central Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1927

7 AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Hampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mattie Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records Johns Hopkins Hospital. (Address)

15 Filed 11 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from 7-2 19 27 to 7-2 19 27 that I last saw him alive on 7-2 19 27 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Contracted pelvis - hard labor (duration) 10 hours

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) K Boerner, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Exact statement of OCCUPA- See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 101-001

CERTIFICATE OF DEATH

E 23833 E 23833

1-PLACE OF DEATH University Hospital 24-35 REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Wesley Fowman

(a) RESIDENCE NO. 1343 Fobsu Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced. HUSBAND of ~~WIFE of~~: Marie Fowman

6 DATE OF BIRTH (month, day, and year): Aug 4 1897

7 AGE: Years 30 Months 11 Days 6

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Duncan Fowman

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Booth

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Marie Fowman

(Address): 1343 Fobsu St.

15 Filed JUL 11 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: 7/10/

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 10 1927.

that I last saw him alive on July 10 1927.

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Empyema of right pleural Cavity

(duration) yrs. mos 20 da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 7 days yrs. mos. da.

18 Where was disease contracted Not definitely known

If not at place of death*:

Did an operation precede death? Yes Date of July 4, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jarvis Otis Pelstayntor, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

Date of Burial: 7/13 19 27

20 UNDERTAKER: Otis Cook

ADDRESS: 501 E Nath.

RH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23834

CERTIFICATE OF DEATH.

38 E 23834

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. 713 WARD)

2-FULL NAME Henry C Otto.

(a) RESIDENCE NO. 1510 E Chase ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth N. Otto.

6 DATE OF BIRTH (month, day, and year): Jan 26 1878

7 AGE: Years 49. Months 5 Days 14 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. md

PARENTS

10 NAME OF FATHER: John F. Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Rolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mrs Elizabeth Otto 1510 E Chase st

15 Filed 1-1 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1927 to July 10, 1927 that I last saw him alive on July 8, 1927 and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Culture Pos

(Signed) Elizabeth Sherman, M. D.

19 (Address) Franklin & Eutaw Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 7/12 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E Nall Ave

See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23835

CERTIFICATE OF DEATH.

44 ✓ E 23835

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hosp. St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Shuler.

(a) RESIDENCE NO. 2236 E. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanie Shuler

6 DATE OF BIRTH (month, day, and year) Oct 10 1860

7 AGE: Years 66 | Months Oct 9 | Days 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John Shuler

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Anna Duff

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mrs Mary Shuler.

(Address) 2236 E Hoffman St

15 Filed OCT 1 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-9-27

17 I HEREBY CERTIFY, That I attended deceased from 5-27, 1927 to 7-9-, 1927, that I last saw alive on 7-9, 1927, and that death occurred, on the date stated above, at 1 15 A. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma - Left side with metastasis to Liver and Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (Broncho) (duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Exam, X ray & autopsy

(Signed) Geo Knapp, M. D.

7-9 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraus Date of Burial July 12 1927

20 UNDERTAKER: D. Bernard Fink ADDRESS: 1324 Eutaw Place

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 113 ✓ E 23836

E 23836

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospi St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Calvin Flook

(a) RESIDENCE NO. 807 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day....hrs. or....min.
3	31/2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Frederick Co., Md

PARENTS

10 NAME OF FATHER Lloyd Flook

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Pauline

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wash. Co., Md.

14 Informant C.T.K. Gladhill
(Address) Middletown, Md.

15 Filed JUL 11 1927 R.H. JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syntomatic Pupura

Undetermined Toxemia (probably Gastro-intestinal)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) J. Calvin Flook, M. D.
(Coroner)

7/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Md Date of Burial 7/13 1927

20 UNDERTAKER C.T.K. Gladhill ADDRESS Middletown Md

Issue subject to instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Dr Ferry 910 W Lombard St

E 23837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12/ E 23837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1016 W Fayette ST. (or AVE.) 18 (WARD)

2-FULL NAME Carrie Birchner

(a) RESIDENCE NO. 1016 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Balthasar Birchner

6 DATE OF BIRTH (month, day, and year): Feb 28 1845

7 AGE: Years 82 | Months 4 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): London

PARENTS

10 NAME OF FATHER: John Tills

11 BIRTHPLACE OF FATHER (city or town) (State or country): London

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): London

14 Informant: Mrs Mary Speg (Address) 1016 W Fayette St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4/ 1927, to July 10 1927, that I last saw her alive on July 10 1927, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chr Dig Dept

Arteriosclerosis (duration) unknown yrs. mos ds.

CONTRIBUTORY — (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Usual

(Signed) Bernard Ferry, M. D.

7/11/27 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: July 13 1927

20 UNDERTAKER: William Lee

ADDRESS: 542 E Pratt

FROM IS very important See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23838

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 E 23838

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No 2031 Fredericka St. 20-28 WARD)

2-FULL NAME Mary Virginia Stolzenbach

(a) RESIDENCE NO 2031 Fredericka ST WARD
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Stolzenbach

6 DATE OF BIRTH (month, day, and year) Sept 17 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Basil McKew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Husband
(Address) 2031 Fred. a

15 Filed ... 19 ... Registrar
JUL 11 1927 C. HAMPSON DAVIS, M. D.
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 1927, to July 10, 1927, that I last saw h[illegible] alive on July 10, 1927, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H Wolff, M. D.

7/14/27 (Address) 1843 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	7/13 27
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North ave

Fill out statement of OCCUPA- ... instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 ✓

E 23839

~~E 23839~~

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital St. 7-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elsie Griswold

(a) RESIDENCE NO. 3603 Phila. Ave. Balto. ~~Md~~ St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~5~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward M. Griswold

6 DATE OF BIRTH (month, day, and year): March 4. 1883

7 AGE — Years: 44 — Months: 4 — Days: 7 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House ~~Keeper~~

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER: Leo John Stratinger

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Helia Crowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Edward M. Griswold

(Address): 3603 Philadelphia ave.

15 Filed: JUL 11 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1927, to July 11, 1927.

that I last saw ~~him~~ alive on July 10/10.30 A.M. 1927.

and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess

(duration) ..... yrs. ..... mos 14 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos ..... da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 7/3/27

Was there an autopsy? No

What test confirmed diagnosis? ~~Symptoms signs~~

(Signed) H. Laurence Gabrins, M. D.

July 11, 1927 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

Date of Burial: July 13 1927

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light

IMPORTANT: Physicians should state CAUSE of death so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 23840

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. C E 23840

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 4410 Kathland ave St.) (WARD) 28-6th

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME J. Thomas Streckfus

(Residence in Baltimore: No. 4410 Kathland ave St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct. 26, 1871 (Month) (Day) (Year)

7 AGE: 55 yrs. 8 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sea Food Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: John Streckfus

11 BIRTHPLACE OF FATHER (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary Merritt

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mellie Streckfus

(Address) 4410 Kathland Ave.

15 JUL 11 1927 G. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 9, 1927 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1926 to July 8 1927 that I saw h[illegible] alive on July 8, 1927 and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation &
Myocardial Degeneration

(Duration) yrs. 9 mos. ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) ? yrs. mos. ds.

(Signed) Stanley McElfresh M. D.

, 191 (Address) 1609 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Park Cem. DATE OF BURIAL: July 12, 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1422 Light St.

Use instructions on back of certificate. Exact statement of OCCUPATION be properly classified. PHYSICIANS should

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23841

CERTIFICATE OF DEATH

84 E 23841

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Rogers

(a) RESIDENCE NO. Scranton – Pa St. Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. B. T. Rogers

6 DATE OF BIRTH (month, day, and year) Jan 15 1863.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	64	5	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Wisconsin

PARENTS

10 NAME OF FATHER Henry M. Mead

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Vermont

12 MAIDEN NAME OF MOTHER Mary Lum Mead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) – Ohio –

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed JUL 11 1927 By R. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20 1925 to July 11 1927

that I last saw h[illegible] alive on July 11 1927

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumour

0 0

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted Pennsylvania

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical Examination

(Signed) Oskar Mitchell, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest-Lutheran Cem. Date of Burial July 12 1927

20 UNDERTAKER John O. Mitchell Sons ADDRESS 1900 Eutaw Pl

Very important. See instructions on back of certificates. Last statement of OCCUPATION is

Spec.-7-17-26-A Co.-200 Bks.

(Emma Musson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23842

CERTIFICATE OF DEATH

E 23842

74001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Musson

(a) RESIDENCE NO. 614 S. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Richmond Va.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. (Registrar)

JUL 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/ 1927

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1927, to July 9, 1927

that I last saw h.. alive on July 9, 1927

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - right

arteriosclerosis

Hypertension - cerebral

hemorrhage (duration) yrs. mos. 3 ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General + Sale

(Signed) C. Holmes Davis, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. — Date of Burial July 12 1927

20 UNDERTAKER John H. Scudieri — ADDRESS 1027 Druid Hill

GIVE ALL INFORMATION REQUESTED. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH must be stated so as to show disease, if any, which caused death, or which was the primary cause, and the contributory (secondary) causes, if any, which aggravated it. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23843

CERTIFICATE OF DEATH.

129

E 23843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 W. Hughes ST. 22-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Dawson

(a) RESIDENCE NO. 134 W. Hughes ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Dawson

6 DATE OF BIRTH (month, day, and year): Mar 1st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?)

14 Informant (Address): Mary Dawson 211 W. Pennsylvania Ave

15 Filed 12 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927 to July 9, 1927.

that I last saw h[illegible] alive on July 9, 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about 1 yrs mos ds. (duration)

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. H. Stanworth M. D.

7/11, 1927 (Address) 801 Stags Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 12, 1927

UNDERTAKER: John H. Sowden — ADDRESS 1021 Laurel Hill

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATIONS should state

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 23844

E 23844

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balt. Gen. Hospital 1213 Light St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mary Solun

(a) RESIDENCE NO. 1802 East Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married, Widowed,~~ or Divorced, (~~write the word~~): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 15 1861

7 AGE: Years 66 | Months 3 | Days 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: at Home

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Moritz Solun

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Muller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Anna Mozey

(Address): 5114 Park Heights Av

15 Filed JUL 12 1927 C. HAMPSON JORDAN, M. D. Registrar

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 8 1927, to July 9, 1927, that I last saw her alive on July 9, 1927 and that death occurred, on the date stated above, at 2 49/60 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma body of Uterus

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted ?

If not at place of death!

Did an operation precede death? yes Date of July 5 1927

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Exam

(Signed) C. H. Thompson, M. D.

, 19 (Address) 837 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — Date of Burial 7/12 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

(Instructions on back of certificate. Statement of OCCUPATION is required.)

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23845

CERTIFICATE OF DEATH

105 E 23845

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2223 Roslyn Ave St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Rothart Eidman

(a) RESIDENCE NO. 2223 Roslyn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ferd L. Eidman

6 DATE OF BIRTH (month, day, and year): May 16-1879

7 AGE — Years: 48 Months: 1 Days: 23 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Home

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: J. H. Rothert

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Klingelhoefer

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Ferd L. Eidman

(Address) 2223 Roslyn Ave

15 Filed July 12 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 27, 19 27, to July 9, 19 27,

that I last saw her alive on July 9, 19 27,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Bronchial asthma

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John L. C. Blake M. D.

7-12 19 27 (Address) 1014 N Fa Sayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — Date of Burial: July 12 19 27

20 UNDERTAKER: H. Thuman & Sons — ADDRESS: Norfolk

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23846

CERTIFICATE OF DEATH

90 E 23846

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 135 S. First St. Brooklyn Ward 25-15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Creager

(a) RESIDENCE NO. 135 S. First St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Walter Creager

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Falk

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Allen N. Shipley

(Address) 135 S. 14th St. Brooklyn

15 Filed JUL 12 1927 19 C. HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1927, to July 14th, 1927, that I last saw her alive on July 10th, 1927, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Chronic aortic regurgitation

(duration) — yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted? At place of death

If not at place of death:

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Tony Fleischer M. D.

7/12, 1927 (Address) 127 N. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial July 13, 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23847

CERTIFICATE OF DEATH.

E 23847

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1045 Myrtle Av St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Boyer

(a) RESIDENCE NO. 1045 Myrtle Av St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: femal

4 Color or Race: Colerd

5 Single, ~~Married,~~ Widowed, or ~~Divorced,~~ (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjaman boyer

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: 62 Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Baltimore md

PARENTS

10 NAME OF FATHER: William bankk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): md

12 MAIDEN NAME OF MOTHER: Rohrdymiller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): md

14 Informant: Husband grdr

(Address): 1045 myrtle ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

JUL 12 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

July 9

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to July 9, 1927, that I last saw h.. alive on July 8, 1927, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Carcinomata (Gastric)

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H S McCard M. D.

7/11, 1927 (Address) 2005 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial July 12 1927

20 UNDERTAKER: John W. Toadvin ADDRESS 1027 Druid Hill

Instructions on back of certificates.

Exact statement of OCCUPATION is

Cor. 12-9-25 C 200 Bks.

E 23848

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23848

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1739 Orleans St. 69 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Barnes

(a) RESIDENCE NO. 1739 Orleans St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Richard Barnes

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant James Barnes

(Address) 618 Shutton St

15 Filed _____, 19____ C. HAMILTON JONES, M. D.

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure(Probably Myocardial)

(Died seated at table 8.30 P. M.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Collins M. D.

(Coroner)

7/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — Date of Burial: July 13 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Orleans st

Instructions on back of certificate. EXACT STATEMENT OF OCCUPATION IS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23849

E 23849

188-003

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rzepkowski

(a) RESIDENCE NO. 3035 Elliott St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonina Rzepkowski

6 DATE OF BIRTH (month, day, and year) unknown 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Poland

PARENTS

10 NAME OF FATHER James Rzwpkowski

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Wife

(Address)

15 Filed _____ 19___ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Extravasation of urine
Fractured pelvis & ruptured bladder on July 1/27. While cranking truck up home — accidental

CONTRIBUTORY (Secondary) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Watts M. D.
(Coroner)

7/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary	July 13- 19 27

20 UNDERTAKER F W Ozazewski ADDRESS 1930 Eastern Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RUTH HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23850

E 23850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Eastwood ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Radcliffe

(a) RESIDENCE NO. 1424 Eastwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Radcliffe

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47 Months 10 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: John Radcliffe

(Address) 1424 E. Lombard St

Filed JUL 12 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1927

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to July 10, 1927,

that I last saw h alive on July 10, 1927,

and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Bernard Sacks M. D.

, 19 (Address) 39 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Calvert County

DATE OF BURIAL: July 13 1927

20 UNDERTAKER: Jos. T. H. Rochester

ADDRESS: 111 Jefferson St

IMPORTANT. Answer all questions in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23851 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ E 23851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 814 N Castle St., 7-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Piska

(a) RESIDENCE NO. 814 N. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vaclav Piska

6 DATE OF BIRTH (month, day, and year) July 1860

7 AGE Years 67 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Josef Stverak

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Wenzel Piska

(Address) 814 N Castle St

Filed JUL 12 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15th 1927, to July 11th 1927, that I last saw h[im] alive on July 10th 1927, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH was as follows:

Chronic Valvular Heart disease (Mitral stenosis)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test of diagnosis? Clinical

(Signed) H. A. Meg M. D.

7/11, 1927 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Date of Burial July 13 1927

20 UNDERTAKER Frank Crockson ADDRESS 1906 Bland St

Instructions on back of certificates. Full statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

Robson 2nd Burn

E 23852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 23852

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1748 E Lombard St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Dunn

(a) RESIDENCE NO. 1748 E Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary Dunn

6 DATE OF BIRTH (month, day and year): April 1 1867

7 AGE: Years 60 Months 3 Days 9 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond. Va.

PARENTS

10 NAME OF FATHER: Michael Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orland

12 MAIDEN NAME OF MOTHER: Emma Redmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Orland

14 Informant (Address): Mrs Dunn 1748 E Lombard St

Filed JUL 12 1927 W. H. THOMPSON, M. D. Registrar Hill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 21st 1927 to July 4th 1927, that I last saw h alive on July 4th 1927 and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Surgical Anatom M. D.

7/11/27 (Address) 1-4 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 13 1927

20 UNDERTAKER: Mendel Diffendal — ADDRESS: 378 Mn

Spec.–7-17-26—A Co.—200 Bks.

E·23853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E·23853

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Natale Bosclari

(a) RESIDENCE NO. 1512 Fulton Ave St. Ward Baltimore Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H-C- Bosclari

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) U-Car

(State or country)

PARENTS

10 NAME OF FATHER Malcolm Holden

11 BIRTHPLACE OF FATHER (City or town) U. Car.

(State or country)

12 MAIDEN NAME OF MOTHER Flax Hartsell

13 BIRTHPLACE OF MOTHER (city or town) S. Car.

(State or country)

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

Filed DEC 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4 1927 to July 12 1927

that I last saw h-e alive on July 12 1927

and that death occurred, on the date stated above, at 7 30 P. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Glioma)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 1927

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Geo. L. Tenney, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Burnham Allo	7/12/27
20 UNDERTAKER	ADDRESS
Joseph Abrams	721 Bway

PHYSICIANS should state CAUSE of death in such terms that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23854

20 E 23854

CERTIFICATE OF DEATH

X 100-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE. (No.) JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child Prisment

(a) RESIDENCE NO. Thomas, W. Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	5	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 12 1927 Per C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27 1927 to July 11 1927

that I last saw h.... alive on July 11 1927

and that death occurred, on the date stated above, at 12 N m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Bronchopneumonia

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

upon arrival in hospital (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? West Virginia

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Boyles Jones, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thomas W Va

Date of Burial 7/12/27

20 UNDERTAKER Joseph Ahrens

ADDRESS 711 Bway

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is ... PHYSICIANS should state CAUSE ... may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

E 23855 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23855

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Park Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Catherine Williams

(a) RESIDENCE NO. 1523 Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E Williams

6 DATE OF BIRTH (month, day, and year) July 15-1864

7 AGE Years 62 Months 11 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thos Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant George E Williams

(Address) 1523 Park Ave

15 Filed OCT 12 1927 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th 1926, to July 12th 1927, that I last saw her alive on July 11th 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Grand Carcinamatosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Canada

Did an operation precede death? Yes No Date of 1912

Was there an autopsy?

What test confirmed diagnosis? Physical diagnosis

Signed- G Lenox Lowe M.D.

Oct 12 1927 (Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL July 13th 27

20 UNDERTAKER Peterson & Son ADDRESS 1723 W Lafayette Ave

21 [illegible]

Instructions on back of certificates.

Issued Statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

E 23856

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23856

127-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1329 N. Central Ave St. 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Micheal B. Roddy

(a) RESIDENCE NO. 1329 N. Central Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Moran Roddy

6 DATE OF BIRTH (month, day, and year): Jan 16 1867

7 AGE — Years: 60 | Months: 5 | Days: 25 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Water Dept

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Micheal J Roddy

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Mooney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant (Address): D. Roddy 1329 N. Central Ave

15 Filed JUL 12 1927 C. HAMPSON JONES, M. D. Registrar

By H Lasch

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 11. 1927

17 I HEREBY CERTIFY that I attended deceased from ~~June~~ 26. 19 27 ~~July~~ 11 19 27.

that I last saw him ~~alive~~ on July 10 19 27

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

Signed Benj H Hampson M. D.

7/12 19 27 Address 1216 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem Date of Burial: July 13 1927

20 UNDERTAKER: Mary M Wadefeld ADDRESS: 501 E 25 St.

Instructions on back of certificates. Exact statement of OCCUPATION is necessary. Also CAUSE

E 23857
Spec.–7-17-26—A Co.—200 Bks.

204660

E·23857

HEALTH DEPARTMENT—CITY OF BALTIMORE

X65-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Thompson

(a) RESIDENCE NO. 165 S. Main St. Ward Chambersburg Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 31 1924

7 AGE — Years: 2½ — Months: 6 — Days: 11 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) Pa —
(State or country)

PARENTS

10 NAME OF FATHER Clara Thompson

11 BIRTHPLACE OF FATHER (City or town) Pa —
(State or country)

12 MAIDEN NAME OF MOTHER Eva. Hammersla

13 BIRTHPLACE OF MOTHER (city or town) Pa —
(State or country)

14 Informant Friends —
(Address)

15 Filed JOHNS HOPKINS HOSPITAL M.
JUL 12 1927 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7 1927 to July 12 1927.

that I last saw her alive on July 12 1927.

and that death occurred, on the date stated above, at 8:55 A. m.

The CAUSE OF DEATH* was as follows:

Aleukemic Leukemia
(Lymphoid)

(duration) yrs mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted /

If not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No /

What test confirmed diagnosis? /

(Signed) J. Sheraghty M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg, Penna — Date of Burial: July 14 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

STEWART & MOWEN COMPANY
108 W. NORTH AVE.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE of death in such terms that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

Kelly

E 23858 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 23858

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 325 E. 25th. (St) 12-50 (Ward)

REGISTERED NO

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Catherine Ann Kelly

(a) RESIDENCE (No) 325 E. 25th. (St) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? 73 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Patrick F. Kelly

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John E. Rochford

(Address) 325 E. 25th. St.

15 Filed JUL 12 1927 C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/27

17 I HEREBY CERTIFY, That I attended deceased from 7/11/20 to 7/11/27, that I last saw her alive on 7/11/27, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro sclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) 1 yrs. mos. 1 hour.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Gaddess M. D.

7/12/27 (Address) 321 E. 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 7/14 19 27

20 UNDERTAKER Henry B. Pearson Inc

ADDRESS 805 Calvert

Important—See instructions on back of certificates. Exact statement of OCCUPATION and CAUSE OF DEATH are properly classified.

Spec.—7-17-26—A Co.—200 Bks.

Craig

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23859

38 E 23859

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 538 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Craig

(a) RESIDENCE NO. 122 Colvin st. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 10 0

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Joseph Craig

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Elizabeth Pitts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

Filed JUL 12 1927

Registrar

1526

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 19 26 to July 7 19 27,

that I last saw h im alive on July 7 19 27,

and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

7-8-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

Be sure that every item of information be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23860

CERTIFICATE OF DEATH.

31 E 23860

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 325 Hendricks St. 4-30 Ward)

2-FULL NAME Jos Hendricks.

(a) RESIDENCE NO. Not Known St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): —

(State or country)

PARENTS

10 NAME OF FATHER: —

11 BIRTHPLACE OF FATHER (city or town): —

(State or country)

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country)

14 Informant: —

(Address)

15 Filed JUL 12 1927 by E. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edocarditis

(Duration) yrs. mos. ds.

(Signed) Jno. G. Clark M. D.

(Coroner)

1927 (Address) 140 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Cut on dotted lines and present this certificate. Exact statement of OCCUPATION is required. See instructions on back of certificate.

Cor—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23861

CERTIFICATE OF DEATH

68 E 23861

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Allen Gray

(a) RESIDENCE NO. 1615 Madison Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: mulatto colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1902

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer

(b) General nature of industry, business, or establishment in which employed (or employer): 067

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Barbados

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant ... H. M. Dietz Colic

(Address) Penna Ave.

Filed HAMPSON JONES, M. D.

DEC 12 1927 Registrar

1528

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) January 27, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Morphine Poisoning (acute)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) and other toxic

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.

(Coroner)

(Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

See instructions on back of certificate. Exact statement of OCCUPATION is absolutely essential. Should state CAUSE

UNIVERSITY OF MARYLAND

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23862

CERTIFICATE OF DEATH

38 E 23862

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 Lewis St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas Handy

(a) RESIDENCE NO. 503 Lewis St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Thomas

6 DATE OF BIRTH (month, day, and year): Mar 2 1882

7 AGE: Years 45 Months 4 Days 0 — IF LESS than 1 day ..... hrs. or ..... min.

1882 Mar 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto — Md

(State or country)

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (City or town) unk

(State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk

(State or country)

14 Informant Susie Thomas

(Address) 503 Lewis St.

15 Filed JUL 12 1927 C. HAMPSON JONES, M. D. Registrar

1529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 6 19 27 to July 7 19 27

that I last saw h[illegible] alive on July 7 19 27

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

Urethral Fistula

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted no

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

July 7 19 27 (Address) 503 Lewis St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very important. See instructions on back of certificates. Use ink and write plainly. Do not abbreviate. Answer every item or information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—7-17-26—A Co.—200 Bks.

E 23863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 ✓

E 23863

REGISTERED NO. 28-69

1-PLACE OF DEATH

City of BALTIMORE: (No. 4411 Groveland Ave St. 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine T. Love

(a) RESIDENCE NO. 4411 Groveland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph W. Love

6 DATE OF BIRTH (month, day, and year): February 22-1864

7 AGE: Years 63 Months 5 Days 18 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Michael Grant

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Haney

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Lola Marie Sanders

(Address) 4411 Groveland ave

15 Filed JUL 12 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1925 to July 10 1927

that I last saw h-er alive on July 10 1927

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 20 yrs. — mos. — ds.

18 Where was disease contracted? Place of Death

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John [illegible] M. D.

7/12 1927 (Address) 1219 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 7/14 1927

20 UNDERTAKER: Chas. P. Frank & Son — ADDRESS 118 W. Mt. (Royal ave

Make DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23864

CERTIFICATE OF DEATH.

E 23864

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33rd & Calvert St. 12-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann E. H. Boyle

(a) RESIDENCE NO. 2634 N. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 20 — 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER: James A. Boyle

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER: Julia Hooper

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: Adele B. Mahool

(Address) 2634 N. Charles St

15 Filed 12 1927 19 H. HAMILTON JONES, M. D. Registrar

Per A.R.K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull at base. Accidentally by automobile at Charles & 27th Sts.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Price M. D. (Coroner)

7/12/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 7/14 1927

20 UNDERTAKER: Chas F. Evans & Son ADDRESS 11 S. Howard St

Instructions: Use typewriter or write with ink. Sign name in full. Give usual residence, not business address of informant. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 23865

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23865

CERTIFICATE OF DEATH.

10-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., DH-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Marie Watson

(a) RESIDENCE No. 121 E. Cross St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER J. T. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Hazel Aten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs J. T. Watson

(Address) 121 E Cross St

15 Filed JUL 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to July 12, 1927, that I last saw h[illegible] alive on July 12, 1927, and that death occurred, on the date stated above, at 505 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria and Bronchopneumonia

(duration) yrs. mos 6 2 ds.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated - 5-17-27 Date of Lumbar Puncture 7-9-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pos. Culture

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 13, 27

20 UNDERTAKER Chas. L. Stevens

ADDRESS 1000 E Fort Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.--12 9.25--A Co.--200 Bks.

23866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 ✓

E 23866

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No.) St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Rose McCullen

(a) RESIDENCE NO. 2800 N Charles St. Seton High School St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
47	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sister of Mercy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. Y.
(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town)
(State or country) " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) " "

14 Informant Sister Genevieve
(Address) 2800 N Charles St

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11 1927

17
I HEREBY CERTIFY, That I attended deceased from 6-20 1927 to 7-11, 1927,
that I last saw her alive on 7-11, 1927,
and that death occurred, on the date stated above, at 4.50 a.m.

The CAUSE OF DEATH* was as follows:
Brain Tumor - (Type not determined.)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (?)
If not at place of death
Did an operation precede death? yes Date of 6-22-27 Decompression
Was there an autopsy? no
What test confirmed diagnosis? clinical data

(Signed) O. J. Knapp, M. D.
7-11, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial 7-13-27

20 UNDERTAKER Martin Mayers ADDRESS Baltimore

Exact statement of OCCUPATION and CAUSE of DEATH required. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23867

CERTIFICATE OF DEATH.

90 E 23867

REGISTERED NO.

1-PLACE OF DEATH Bon Secours Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10-15 ST. WARD)

2-FULL NAME Miss Margaret Mackin

(a) RESIDENCE NO. 600 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/1/1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francis Mackin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 Informant Miss C Chase (Address) 600 E Chase St

15 Filed JUL 12 1927 T. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to July 10, 1927, that I last saw her alive on July 10, 1927, and that death occurred, on the date stated above, at 12 m. p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George D. Eaton, M. D.

19 (Address) Bon Secours Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7/13/1927

20 UNDERTAKER J J Foley & Son — ADDRESS 1318 Light

(Instructions on back of certificates. Make statement of OCCUPA-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23868

CERTIFICATE OF DEATH.

E 23868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1948 W. Lafayette St. 16-27 Ward)

2-FULL NAME Mary Zell

(a) RESIDENCE NO. 1948 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Earl Heis

6 DATE OF BIRTH (month, day, and year): 10/22/63

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town):

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Th Murphey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Cosgrove

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: Thos Rogers

(Address) 1948 W Lafayette

15 Filed 12 1927, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, and from (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) G. C. Jamison M. D.

(Coroner)

1927 (Address) 702 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge | Date of Burial: July 31 1927

20 UNDERTAKER: G. J. Tobey Sons | ADDRESS: 131 Light

G. HAMPSON JONES, M. D.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is necessary. Also cause of death must be correctly classified. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

E 23869

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23869

CERTIFICATE OF DEATH

Duplicate

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO. 16-23

City of BALTIMORE: (No. [redacted] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agrelma White

(a) RESIDENCE NO. 606 W. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 66 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Oto

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Bernard White

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Charity ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed JUL 12 1927 16 C. HAMPSON JONES, M. D. Registrar

By R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/10/ 1927

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1927, to July 10, 1927

that I last saw h[illegible] alive on July 10, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chr. & acute

Arteriosclerosis

Hypertension

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. & Surg.

(Signed) C. Hampson Jones, M. D.

1927 (Address) BALTIMORE CITY H[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bayview Chapel Colored Co. Date of Burial July 13 1927

20 UNDERTAKER: Sam'l W. Crane Son ADDRESS 1400 Mosher

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Every item of information must be stated EXACTLY. PHYSICIANS should state CAUSE

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23870
1-PLACE OF DEATH

90 E 23870
REGISTERED NO.

City of BALTIMORE: (No. 322 S Wolfe St St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Drozdowska

(a) RESIDENCE NO. 322 S Wolfe St St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS
10 NAME OF FATHER Antoni Drozdowska
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Poland
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Agnes West
(Address) Sparrows Point & North Point

15 Filed JUL 12 1927 16 H. MELTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 9 1927

I HEREBY CERTIFY, That I attended deceased from July 7 . 19 27 to July 9 . 19 27
that I last saw her alive on July 6 . 19 27
and that death occurred, on the date stated above, at 4 30a m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Disease of Heart

1 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac Asthma

1 (duration) yrs. mos. ds.
18 Where was disease contracted —
if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) [illegible] M. D.
7/11 . 19 27 (Address) 6 North Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Date of Burial July 13 1927

20 UNDERTAKER John M Weber ADDRESS 1503 North

IMPORTANT. Every item of information called for in this CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23871

CERTIFICATE OF DEATH

X41 E 23871

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Maryland General St. 1124 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Homer Ward

(a) RESIDENCE NO. Upperco, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): August 5, 1904

7 AGE: Years 22 Months 11 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Gray Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER G. R. Ward

11 BIRTHPLACE OF FATHER (City or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nancy Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hosp. Records

(Address)

15 Filed JUL 12 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-10-27, 19 , to 7-12-27, 19 .

that I last saw h. (M) alive on 7-12-27 19 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Streptococcus Empyema

and

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-10-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M. D.

19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fries, Virginia — Date of Burial: July 13, 1927

20 UNDERTAKER: E. Leroy Stiffler — ADDRESS: 125 E. North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23872

CERTIFICATE OF DEATH.

1135

E 23872

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2208 E Hoffman St., 6-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa C. Scherer

(a) RESIDENCE NO. 2208 E. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 29 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. 1 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 12-1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Scherer

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Troup

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant John Scherer

(Address) 2208 E Hoffman St

15 Filed JUL 13 1927 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-11-27

17 I HEREBY CERTIFY, That I attended deceased from July 1- 19 27 to July 11 19 27

that I last saw h alive on July 11 19 27

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH was as follows:

Pneo - Colitis acute

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 7-12-27 800 N Dul Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial July 13, 27

20 UNDERTAKER Jas C. Miller & Son ADDRESS 2334 Jeffer

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is required. Also CAUSE

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23873

CERTIFICATE OF DEATH

7 E 23873

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph's Hosp. Ward) 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Grebe

(a) RESIDENCE NO. 103 Birchwood Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Widowed~~ Frederick Grebe

6 DATE OF BIRTH (month, day, and year): June 22 1860

7 AGE: Years 67 Months 0 Days 19 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: ~~John~~ Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Grebe

(Address) 103 Birchwood Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

7 13 1927 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/4/ 1927 to 7/11/ 1927

that I last saw h.. alive on July 11 1927

and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Cholothiasis c empyema of gall bladder

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 7/8/27

Was there an autopsy? no

What test confirmed diagnosis? Xray, gross path.

(Signed) H. Laurence Fahnestock, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 7/14 1927

20 UNDERTAKER: George J Ruth ADDRESS 1730 Hanford ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23874 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 / E 23874

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Cedar Ave ST. 13-51 WARD)

2-FULL NAME Charles D. Magaha

(a) RESIDENCE No. 3017 Cedar Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Kate Magaha.

6 DATE OF BIRTH (month, day, and year) June 14, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Kate Magaha

(Address) 3017 Cedar Ave

15 Filed JUL 13 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927, to July 10, 1927.

that I last saw h[illegible] alive on July 10, 1927

and that death occurred, on the date stated above, at 11 57 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) M. Smith, M. D.

July 11, 1927 (Address) 847 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL July 13 1927

UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23875

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23875

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 236 S. High St. 35 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Mussumeci

(a) RESIDENCE No. 236 S High St., 3 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 12 1926

7 AGE — Years: — Months: 7 Days: 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Mussumeci

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Iovani Carnago

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Louis Mussumeci

(Address) 236 S High St

15 Filed JUL 13 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 12, 1927, that I last saw him alive on July 12, 1927, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Scagnetti, M.D.

, 19 (Address) 244 S. Exeter St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL July 14 19 27

UNDERTAKER Frank V. Pistorio — ADDRESS 281 E Balto

TION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

90462 8

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23876

CERTIFICATE OF DEATH

12 9 E 23876

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Cohen

(a) RESIDENCE NO. 10 E Altamont St. ff Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Cohen

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Furniture

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Hirsh Cohen

11 BIRTHPLACE OF FATHER (City or town) ____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 13 1927 19 C. HAMPSON JONES, M. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1927 to July 12, 1927

that I last saw h living alive on July 12, 1927

and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic nephritis

Renal Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. mos. ds.

18 Where was disease contracted Baltimore

if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) E. Cowles Andrus M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rod Date of Burial 7/13 1927

20 UNDERTAKER Jack Levin ADDRESS 439 E Baltimore St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23877

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 Dolphin ST. 17-23 WARD)

2-FULL NAME Wm E. Jones

(a) RESIDENCE NO. 760 Dolphin ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lilian Jones

6 DATE OF BIRTH (month, day, and year) Sept. 15 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Aaron Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rena Dobson
(Address) 760 Dolphin St

15 Filed 13 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to July 10, 1927, that I last saw h[illegible] alive on July 7, 1927 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Frank E. Magnus, M. D.

7/13/1927 (Address) 1016 E. Fairmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL July 13 1927

20 UNDERTAKER Samuel Heisler ADDRESS 37 N Eden

NOTICE IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Bks.

E 23878

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23878

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 357 S. Smallwood ST. 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Kapraun

(a) RESIDENCE No. 357 S. Smallwood ST. 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Kapraun

6 DATE OF BIRTH (month, day, and year) Sept 8th 1855

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
73	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrad Kapraun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mukmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Kapraun

(Address) 357 S. Smallwood

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10th 27

17 I HEREBY CERTIFY, That I attended deceased from June 10 . 19 27 . to July 10 . 19 27 .

that I last saw him alive on July 9 19 27

and that death occurred, on the date stated above, at 9:15 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj S Warren, M. D.

7/11, 19 27 (Address) 420 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 13 1927
20 UNDERTAKER	ADDRESS
F. B. Kefpect	1532 N Paca St

JUL 13 1927 C. HAMILTON JONES, M.

Spec.—8-24-14—M. & T.—2000 Bks.

E 23879

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Monroe St. 16-27 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Bochera

(Residence in Baltimore: No. 612 N. Monroe St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Apr 5, 1848 (Month) (Day) (Year)

7-AGE, 79 yrs. 3 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Bochera

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Schaffer

(Address) 2811 Hamlen Ave

15- JUL 13 1927 When, 191.. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3rd 1927, to July 11 1927, that I saw h[illegible] alive on July 10 1927, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Contributory 8 days.

(Duration) yrs. mos. ds.

CONTRIBUTORY. Arteriosclerosis

(Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) John D. Clough M. D.

July 11, 1927 (Address) 3610 Fleet Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, July 13rd 1927

20-UNDERTAKER, E. B. Weyant — ADDRESS 1850 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

E 23880 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23880

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Johns Hopkins Hospital~~ St. 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Grenzer

(a) RESIDENCE NO. 1402 E. Lanvale St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Grenzer

6 DATE OF BIRTH (month, day, and year) Jan 27/1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U. S. Guager

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Grenzer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Geo. J. Ruth

(Address) 1735 Harford Ave

15 Filed JUL 13 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 July 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis etc

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

7/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Cemetery Lanvale Date of Burial July 13 1927

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave.

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is necessary as properly classified. Indefinite and illegible answers cannot be accepted. Write plainly. Underline cause which is primary cause of death.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23881

CERTIFICATE OF DEATH.

E 23881

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1205 W. Saratoga St., 16 Ward)

2-FULL NAME Chas. Henry Waters

(a) RESIDENCE NO. 1205 W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-15-1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ... min.
65	66	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Leaf Tobacco Dlr

9 BIRTHPLACE (city or town)

(State or country) Somerset Co. Md

PARENTS

10 NAME OF FATHER Levin Waters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Adeline Cattman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant William Waters

(Address) 1205 W. Saratoga St

15 Filed ..... 19 ..... Registrar

JUL 13 1927

H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-12-27

17 I HEREBY CERTIFY, That I attended deceased from 4-25, 1927, to 7-12, 1927.

that I last saw h alive on 7-11-, 1927.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Carcinoma

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical X Ray

(Signed) H. Carson, M. D.

7/13 1927 (Address) 1050 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: 7/17 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

Very important. See instructions on back of certificates. Cause of death must be properly classified. Exact statement of OCCUPATION is necessary. Underlying cause should state CAUSE

Spec.-7-17-26—A Co.—200 Bks.

E 23882

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23882

159-007

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 27-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sleitzer

(a) RESIDENCE NO. 25 Eigenbrodt Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 31 1927

7 AGE Years: 3 Months: 10 Days: 12 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Wm. Sleitzer

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Maud Hallis

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 13 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30 1927 to July 11 1927

that I last saw her alive on July 11 1927

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Anomaly, Decompensation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J J Geraghty, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: 7/13 1927

20 UNDERTAKER: William Cook

ADDRESS: 501 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23883

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23883

CERTIFICATE OF DEATH.

REGISTERED NO. 13

1-PLACE OF DEATH

City of BALTIMORE: (No. Euclid Av., Mt. Washington) Ward 7-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rose LEWIN

(a) RESIDENCE NO. Euclid Av., Mt. Washington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	married

5a If married, widowed, or divorced ~~Husband of~~ (or) WIFE of John LEWIN

6 DATE OF BIRTH (month, day, and year) SEPTEMBER 10, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) FREDERICK COUNTY

(State or country) MARYLAND

PARENTS

10 NAME OF FATHER PETER SHORB

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER MARY ROSENSTEEL

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant MR. John Lewin

(Address) Euclid av., MT. WASHINGTON

15 Filed JUL 13 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1927, to July 11, 1927, that I last saw her alive on Monday, July 11, 1927, and that death occurred, on the date stated above, at 9 40 p. m.

The CAUSE OF DEATH* was as follows:

CHRONIC INTERSTITIAL NEPHRITIS

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) LESION SPINAL CORD

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? CHRONIC CASE

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? STUDY & TREATMENT

(Signed) A. M. BAGOSIN M. D.

7/11/, 1927 (Address) RANDALLSTOWN, MD.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 7/14 19 27

20 UNDERTAKER J. J. Fahey Sons ADDRESS 1218 Eager St

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is ... should state CAUSE ... properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23884 CERTIFICATE OF DEATH × 90 E 23884

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 26-37

City of BALTIMORE: (No. [redacted] St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Smith

(a) RESIDENCE NO. 104 Patapsco Ave Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40? mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years 48(?) Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 10

(b) General nature of industry, business, or establishment in which employed (or employer) 01

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant BALTIMORE CITY HOSPITALS
(Address) [redacted]

15 Filed JUL 13 1927 19 C. HAMPSON JONES, M. D. Registrar
1539

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/ 1927

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1919, to July 9, 1927, that I last saw h er alive on July 9, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Gross

(Signed) C. Hampson Jones, M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

BALTIMORE CITY HOSPITALS

UNIVERSITY OF MARYLAND

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-15-26–A Co.–200 Blks.

E 23885 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 23885

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3312 Old Frederick Rd. St. 20-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Neighoff

(a) RESIDENCE NO. 3312 Old Frederick Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Neighoff

6 DATE OF BIRTH (month, day, and year) April 19, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	78	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Lawman Young

11 BIRTHPLACE OF FATHER (City or town) Howard County

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mace

13 BIRTHPLACE OF MOTHER (city or town) Howard County

(State or country) Maryland

14 Informant Thomas L. Ray

(Address) Laurel, Md.

15 Filed JUL 13 1927, 19 ... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1927, to July 11, 1927, that I last saw her alive on July 11, 1927, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Right

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

7/17/1927 (Signed) W. A. Neff, M. D.

(Address) 4207 Frederick Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetary

Date of Burial 7/13/27 19

20 UNDERTAKER Joseph B. Cook

ADDRESS 1093 W. Baltimore St.

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 23886

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23886

CERTIFICATE OF DEATH

22-30123

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Univ Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Lemuels

(a) RESIDENCE NO. 644 Washington Blvd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lemuels

6 DATE OF BIRTH (month, day, and year) April 4, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
	69	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Levi Arnett

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Unknown

14 Informant Robert A. Lemuels

(Address) 644 Washington Blvd.

15 Filed JUL 13 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-1927

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 1927 to 7-11, 1927

that I last saw h[er] alive on 7-11, 1927

and that death occurred, on the date stated above, at 3.00 P.m.

The CAUSE OF DEATH* was as follows:

Embolism

Acute myocardial failure

(duration) yrs. Instant mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 6-30-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. J. Henderson M. D.

7/11 1927 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

Date of Burial 7/14/27 19

20 UNDERTAKER Lee & Cook

ADDRESS 1003 W. Baltimore St.

IMPORTANT. PHYSICIANS should state CAUSE plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23887

CERTIFICATE OF DEATH

16 1 201 E 23887

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 S Clinton St 12-2 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Heflein

(a) RESIDENCE NO. 213 S Clinton ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12, 1927

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Paul Conway Heflein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Orange Va

12 MAIDEN NAME OF MOTHER Louise Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant

(Address)

15 Filed 19 Per Registrar

C. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 27

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 27, to July 13, 19 27.

that I last saw h[illegible] alive on July 12 19 27.

and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows

Congenital atelectasis

(Premature birth - 5 mos)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Congenital asphyxia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) Leo Schulz, M. D.

19 (Address) 3034 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 13 1927 JOHNS HOPKINS HOSPITAL

Bureau of Vital Statistics

JUL 13

TION is very important. See instructions on back of certificates.

...ns on plain cards, so that it may be properly classified. Exact statement of OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23888

CERTIFICATE OF DEATH

E 23888

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 16 Ward BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ayelw Bowen

(a) RESIDENCE NO. 610 Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 67 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Reported

15 Filed JUL 13 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922 to July 8, 1927.

that I last saw him alive on July 8, 1927

and that death occurred, on the date stated above, at 12:10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY Arteriosclerosis.

(Secondary)

Myocarditis (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sect.

(Signed) C. Fulmer Berger, M. D.

19 (Address) CITY H [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial 7/12 1927

20 UNDERTAKER: J J Lahey Son — ADDRESS 1018 Eight St

very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23889 — 31 — E 23889

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

City of BALTIMORE: (No. ____ St. ____ Ward) 7th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Bertram Burks

(a) RESIDENCE NO. 812 S. Broadway St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ____

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor.

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Charleston

(State or country): So. Carolina

PARENTS

10 NAME OF FATHER: Henry Burks

11 BIRTHPLACE OF FATHER (City or town): ____

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Roberta Wagner

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country): Germany

14 Informant: Hospital Records

(Address) ____

15 Filed ____, 19 ____ Registrar ____

NOV 13 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 9, 1927.

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 1927 to 7/9, 1927

that I last saw him alive on July 9, 1927.

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

19 (Address) 7/9/27 Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial: 7/12 1927

20 UNDERTAKER: D J Daley Son — ADDRESS: 134 Light St

IMPORTANT: Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-27—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23890

CERTIFICATE OF DEATH

24 E 23890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) 24-34 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Rainier

(a) RESIDENCE NO. 1709 Belt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 23, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Rainier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hilda William

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hilda Rainier

(Address) 1709 Belt St

15 Filed JUL 13 1927 C. HAMILTON [illegible] M. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 12, 1927, that I last saw her alive on July 12, 1927 and that death occurred, on the date stated above at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Meningococcic Meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Lumbar Puncture Date of 7/11/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Spinal Fluid

(Signed) Myron G. Tull, M. D.

7/13, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery DATE OF BURIAL: July 14 1927

20 UNDERTAKER: Fred. A. Fetters & Bro. ADDRESS: 703 [illegible]

Please answer all questions. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23891

CERTIFICATE OF DEATH

E 23891 90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 South Fremont Ave. SK 12-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Buck

(a) RESIDENCE NO. 307 South Fremont Ave SK Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward D. Buck

6 DATE OF BIRTH (month, day, and year) September 1881

7 AGE 45 Years 46 Months 10 Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Emerson

11 BIRTHPLACE OF FATHER (City or town) Alexandria

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Louise Hiser

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Maryland

14 Informant Mrs. Mary Beseling

(Address) 1015 Maldies Street

15 Filed ..... 19 J. HAMPSON JONES, M. D. Registrar

JL 13 1927 Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 7/10, 1927, to 7/12, 1927.

that I last saw her alive on 7/11/27, 1927.

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dunn, M. D.

19 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

Date of Burial 7/15/27 19

20 UNDERTAKER Paul E. Cook

ADDRESS 1003 W. Baltimore St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 23892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23892

CERTIFICATE OF DEATH.

129

REGISTERED NO. W 2640

1-PLACE OF DEATH

City of BALTIMORE: (No. 549 W. Biddle St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sandy Alexander McLeod

(a) RESIDENCE NO. 549 W. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabel McLeod

6 DATE OF BIRTH (month, day, and year): April 11, 1960

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
67	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Masonic Hall

(c) Name of employer: Masonic Order

9 BIRTHPLACE (city or town) (State or country): Raleigh N-C.

PARENTS

10 NAME OF FATHER: Ned McLeod

11 BIRTHPLACE OF FATHER (city or town) (State or country): Raleigh N-C.

12 MAIDEN NAME OF MOTHER: Lucy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Raleigh N-C.

14 Informant: Isabel McLeod

(Address): 549 W. Biddle St.

15 Filed JUL 13 1925, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1927 to July 12, 1927

that I last saw him alive on July 11, 1927

and that death occurred, on the date stated above, at 2:55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis and Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Dr Baltimore Md

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Medical

(Signed) William H. Watts, M. D.

, 19 (Address) 928 Penna ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial July 13 1927

20 UNDERTAKER: Daniel Easton & Co

ADDRESS 916

very important. See instructions on back of certificates.

Certificate of death must be filed with the Registrar of the district in which death occurred before a burial permit can be issued. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23893

CERTIFICATE OF DEATH.

185 E 23893

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Hadley

(a) RESIDENCE NO. 410 Orland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Christine Hadley

6 DATE OF BIRTH (month, day, and year) July 24 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Tonaconing

(c) Name of employer Konahe Co

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Geo Hadley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Lawrence Hadley

(Address) 410 W Orland

15 Filed 7-13 1927 C. HAMPTON JONES, M. D.

Per R.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage by fall down steps at home

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(duration) yrs. 1 mos. 2 ds.

(Signed) James M. Fenton M. D.

(Coroner)

July 11 1927 (Address) 702 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents Only)

At place of death yrs. mos. 25 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 410 W Orland St

Former or usual residence 410 Orland St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tonaconing Md Date of Burial 7/13 1927

20 UNDERTAKER William Cook ADDRESS 502 E Balt St

very important. See instructions on back of certificate.

...it may be properly classified. Exact statement of OCCUPATION is ... PHYSICIANS should state CAUSE

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23894

CERTIFICATE OF DEATH.

10-0032

E 23894
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stach

(a) RESIDENCE NO. 1817 E Eager St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	10	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Stach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Checkslavakia

12 MAIDEN NAME OF MOTHER Mary Seelt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Checkslavakia

14 Informant Mrs Mary Stach
(Address) 1817 E Eager St

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1927, to July 12 1927.
that I last saw her alive on July 12 1927
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. cult.

(Signed) Myron G. Sull, M. D.

7/13, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 14 1927

20 UNDERTAKER Frank Cook Son — ADDRESS 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23895

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jose Gomez

(a) RESIDENCE NO. 11 Union St., Brooklyn N.Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. L. Irenz

9 BIRTHPLACE (city or town) (State or country) South America

PARENTS

10 NAME OF FATHER Ismela Gomez

11 BIRTHPLACE OF FATHER (city or town) (State or country) South America

12 MAIDEN NAME OF MOTHER Anacosta Brasil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South America

14 Informant Hospital Records

(Address)

15 Filed ....., 19 Per C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1926, to July 13, 1927.

that I last saw h[m] alive on July 13 1927

and that death occurred, on the date stated above, at 1 00 [A] m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) / yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous ulceration of larynx (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical findings & laboratory data

(Signed) O W Bruce M. D.

(Address) Asst Surgeon U S P.H.S. U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden DATE OF BURIAL July 14, 1927

20 UNDERTAKER E. Leroy Stiffler ADDRESS 125 E. North ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23896

CERTIFICATE OF DEATH.

E 23896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 301 N Carey St (Street) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orville French

(a) RESIDENCE NO. 301 N Carey St WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 20 1843

7 AGE: Years 84 Months Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary E Keys
(Address) 301 N Carey St

15 Filed JUL 13 1927, 19 Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1927, to July 12, 1927, that I last saw him alive on July 11, 1927, and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Arteio-sclerosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary Glassman M. D.
July 15 1927 (Address) 2687 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: July 14, 1927

20 UNDERTAKER: Chenowith & Son (Chestnut Ave)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23897

CERTIFICATE OF DEATH.

100-001

E 23897

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3453 Ash St. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E. M. Taylor

(a) RESIDENCE No. 3453 Ash St. ST. 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L. Taylor

6 DATE OF BIRTH (month, day, and year) July 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Page Co. Virginia

PARENTS

10 NAME OF FATHER Rev. Thornton Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Annie L. Taylor

(Address) 3453 Ash St.

15 Filed JUL 13 1927 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 13 1927

that I last saw h[illegible] alive on July 12 1927

and that death occurred, on the date stated above, at 6:5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 7 yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) 1 yrs. — mos. — da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [illegible], M. D.

July 14 1927 (Address) 1240 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL July 16 1927

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Feltd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 23898

CERTIFICATE OF DEATH

REGISTERED NO. E 23898

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maggie K. Reed

(a) RESIDENCE NO. Church Home & Infirmary Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: M. Reed.

6 DATE OF BIRTH (month, day, and year): ? ? 1840

7 AGE: Years 87 | Months ? | Days ? | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Calvert Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER: John King

11 BIRTHPLACE OF FATHER (city or town): Calvert Co.

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER: Margaret Hyde

13 BIRTHPLACE OF MOTHER (city or town): Calvert Co.

(State or country) Maryland.

14 Informant: Mrs. Gibson

(Address) University Hosp.

15 Filed JUL 13 1927, 19 C. HAMPSON JONES, M. D. Registrar

By: RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 12th 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 15 19 27 to July 12 19 27, that I last saw h[illegible] alive on July 12 19 27, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH was as follows:

Cerebral Sclerosis

General & Cerebral

CONTRIBUTORY (Secondary): Myocardial Failure (duration) 12 yrs. mos. ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Canon H. Norris M. D.

July 12 19 27 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Paul's Cemetery Calvert Co. Date of Burial July 14 1927

20 UNDERTAKER: Hughes & Jones ADDRESS 420 E. Broadway

IMPORTANT—Every question must be answered if possible. Do not leave out anything because you think it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE should state CAUSE

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23899

CERTIFICATE OF DEATH.

185 E 23899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Luretta Brengle

(a) RESIDENCE No. 1815 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L Brengle

6 DATE OF BIRTH (month, day, and year) April 9-1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Barley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Florence Brengle

(Address) 816 N. Broadway

15 Filed JUL 13 1927, 19 Registrar

C. HAYSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to July 12, 1927, that I last saw h[illegible] alive on July 12, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fracture of Cervical Vertebrae 5-6 & 7th Cervical Vertebrae

Accidental.

(duration) yrs. mos 6 0 ds.

CONTRIBUTORY (Secondary) arteriosclerosis - Myocardial insufficiency

Terminal Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + X ray.

(Signed) C. J. Knapp, M. D.

7-12, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL 7/14 1927

20 UNDERTAKER Wm Coale

ADDRESS Stoll Store

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23900

CERTIFICATE OF DEATH.

90 E 23900

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 905 S. Charles St. St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Levin.

(a) RESIDENCE NO. 905 S. Charles St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, (HUSBAND) of XXXXXXXXXXXXX XXXXXXXXX Ida Levin.

6 DATE OF BIRTH (month, day, and year) March 15, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia.

PARENTS

10 NAME OF FATHER Joseph Levin.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia.

14 Informant Ida Levin, (wife)

(Address) 905 S. Charles St.

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

7/18 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State. .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem. Date of Burial July 14 1927

20 UNDERTAKER ADDRESS

Jack Levin 1434 E. Baltimore St.

very important. See instructions on back of certificate.

Exact statement of OCCUPATION is

CAUSE

should state

CAUSE

PHYSICIANS

so that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 23901

CERTIFICATE OF DEATH.

129

E 23901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2023 E. North Ave (St.) (Ward) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Bier

(a) RESIDENCE NO. 2023 E. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Bier.

6 DATE OF BIRTH (month, day, and year): Feb. 25 1854

7 AGE — Years: 73 — Months: 4 — Days: 17 — If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: John Wesley Brunnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): USA

14 Informant: Mr. Charles A. Bier

(Address): 2023 E. North Ave

15 Filed JUL 14 1927, 19 — HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 24 1927 to July 12 1927; that I last saw h[illegible] alive on July 12 1927 and that death occurred, on the date stated above, at 5.05 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Allan T. Dowling M. D.

7/13 1927 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: July 15 1927

20 UNDERTAKER: Wm. J. Luther Sons.

ADDRESS: North Pa

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 23902

CERTIFICATE OF DEATH

E 23902

REGISTERED NO.

1-PLACE OF DEATH

Thomas B. Strahan

City of BALTIMORE: (No. Balto City Hospital 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas B. Strahan

(a) RESIDENCE NO. 1523 N Caroline St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth J. Strahan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE 83 Years Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Mr. Strahan

11 BIRTHPLACE OF FATHER (City or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mrs. Linn

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Joseph Funkenbusch

(Address) 1523 N Caroline St

15 Filed JUL 14 1927 19 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927 to July 12 1927

that I last saw him alive on July 12, 1927

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Cellulitis Left foot & leg Gangrene of foot

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lymphangitis Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-6-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Holmes Sr. M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: July 15 1927

20 UNDERTAKER: Henry Hook & Son — ADDRESS: 1310 E. Eager

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 23903

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 23903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3721 Center Place St., 26 Ward)

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Fisher

(a) RESIDENCE NO. 3721 Center Place St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 8th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant - [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Frank Fisher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) California.

12 MAIDEN NAME OF MOTHER Margt. Locher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Frank Fisher.

(Address) 3721 Center Place

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 13

I HEREBY CERTIFY, That I attended deceased from July 11, 1927 to July 13, 1927, that I last saw him alive on July 13, 1927, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY Enteritis

(Secondary)

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted Residence

If not at place of death? Residence

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Lapenas, M. D.

July 13, 1927 (Address) 2307 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

Date of Burial: July 14 1927

20 UNDERTAKER: Lilly + Zeibel

ADDRESS: 4038 Wolfe St

JUL 14 1927 HAMPDEN LOWER M. D.

very important. See instructions on back of certificates.

CAUSES should state CAUSE ... may be properly classified. Exact statement of OCCUPATION is

Spec. -7-17-26—A Co.—200 Bks.

E 23904

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23904

CERTIFICATE OF DEATH

REGISTERED NO. 36

1-PLACE OF DEATH

City of BALTIMORE: (No. 6536 Patapsco ave St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn E Ritz

(a) RESIDENCE NO. 6536 Patapsco ave St. 24 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): March 17 — 1927

7 AGE: Years 3 Months Days 24 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Ritz

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Ethel Wilson

13 BIRTHPLACE OF MOTHER (city or town): West Va

(State or country)

14 Informant: Ethel Ritz

(Address) 6536 Patapsco ave

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6 1927 to July 11 1927

that I last saw her alive on July 10 1927

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Chas C Hammond, M. D.

. 19 (Address) 99 Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

Date of Burial: July 14 1927

20 UNDERTAKER: Lilly & Zibel Co.

ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23905

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23905

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 938 Bentalou St., 16-68 Ward)

2-FULL NAME Joseph Eugene Chambers

(a) RESIDENCE NO. 938 Bentalou St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mattie E Chambers

6 DATE OF BIRTH (month, day, and year): Oct [illegible] 1856

7 AGE: Years 70 | Months 8 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town): _____

(State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: John T Chambers

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Ogden

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Md

14 Informant: Mrs John L Tyson

(Address): 838 N Bentalou St

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): ~~July 12 1927~~ July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927, to July 13, 1927,

that I last saw h.. alive on July 12 1927,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage causing Paralysis of right

(duration) ..... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary): Arterial Sclerosis

(duration) Ind yrs. — mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? nv Date of —

Was there an autopsy? nv

What test confirmed diagnosis? Paralysis of R. side

(Signed) Hoo H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Private Church Cemetery Calvert Co Md. Date of Burial: July 15 1927

20 UNDERTAKER: W M Routson ADDRESS 223 N Mt

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23906

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13—W 25—St ST. 17-51 (WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Willis Kroh

(a) RESIDENCE NO. 13 W 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo L Kroh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Roland T Burke

(Address) 520 Park ave Towson Md.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bur — DATE OF BURIAL: July 14 1927

20 UNDERTAKER: W M Corteen — ADDRESS: 2238 N Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important See instructions on back of certificates.

JUL 14 1927 C. HANSON JONES, M.

Cor.—12-9-25—A Co.—200 Bks.

E 23907

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1811 Linden Ave. Ward 20.)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion E Perry

(a) RESIDENCE NO. 1811 Linden Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1926.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Marion Hunter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Viola Perry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mary Perry

(Address) 1811 Linden Ave

15 Filed JUL 14 1927 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Gastro enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Thomas M. D.

(Coroner)

July 13, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial July 14 1927

20 UNDERTAKER Samuel H Hendley & Bro ADDRESS 58

If LESS than one day, hours or minutes, or NEW BORN STILL BORN, the space for NAME must be filled in before a certificate can be issued. PHYSICIANS should state CAUSE of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23908

CERTIFICATE OF DEATH.

1883 23908

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Gath.

(a) RESIDENCE NO. 129 W. Beverly St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. ---- mos. ---- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, XXXXXXXXXXXX
HUSBAND of XXXXXXXXXX Louise Gath.

6 DATE OF BIRTH (month, day, and year) July 14, 1892.

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or.....min.
	34	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship fitter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Nebraska.

PARENTS

10 NAME OF FATHER William Gath.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York.

12 MAIDEN NAME OF MOTHER Jennie Steele.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Chicago, Ill.

14 Informant Louise Gath.(wife)

(Address) 129 W. Beverly St.

15 Filed ..... 19.. C. HAMPSON JONES M. D. Registrar

JUL 14 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Extensive burns of face and body,
fire from an auto truck.
Accidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Pennewell M. D.
(Coroner)

7/18 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? In front of 129 Beverly St. July 12, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: July 15 1927

20 UNDERTAKER: A. Howard Evans ADDRESS: 38 E. Fort Ave

Eyes

Be sure to fill in PLACE OF DEATH, so that it may be properly classified. PHYSICIANS should state CAUSE in plain terms, so that it may be very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23909

100-001

CERTIFICATE OF DEATH.

E 23909

1-PLACE OF DEATH Balto City Hospt

REGISTERED NO.

City of BALTIMORE: (No. 2 Balto Md. St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Durkins

(a) RESIDENCE NO. 1131 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Durkins

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt.

(Address) Balto Md.

15 Filed JUL 14 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-11-27

17 I HEREBY CERTIFY, That I attended deceased from 7-6-, 1927, to 7-11-, 1927, that I last saw him alive on 7-11-, 19 27 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Cardio Renal Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry J. Williams M.D.

7/12, 1927 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Interred and Buried in Mt Auburn Cemetery 7-16 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pennsylvania Ave

THOMPSON-BOYCE PRINTING CO. BALTO.

PHYSICIANS should state CAUSE very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23910

CERTIFICATE OF DEATH

X 3/E 23910

1-PLACE OF DEATH

REGISTERED NO. 26-37

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Brown

(a) RESIDENCE NO. Mellvina, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lif yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Brown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lottie Hammond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed , 19 (HAMPSON JONES, M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 3 27, 19 to July 11, 1927, 19

that I last saw h in alive on July 11, 27, 19

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

7-11-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

JUL 14 1927

1536

Write plainly. Please be careful and supply all items. This is a PERMANENT RECORD. Every item of information is important. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 23911

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 75-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gertrude O'Mara

(a) RESIDENCE NO. 67 Delray Ave St. Catonsville Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Wm O. Mara

6 DATE OF BIRTH (month, day, and year): Dec 24 1891

7 AGE: Years 35 | Months 6 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: John Wetzler

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Dunter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Wm O. Mara

(Address): 67 Delray Ave

15 Filed JUL 14 1927 C. HAMPTON JONES, M. D. Registrar

Fee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-12 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-12-1927, to 7-12, 1927, that I last saw h.. alive on 7-12, 1927, and that death occurred, on the date stated above, at 4 15 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.—

with Coma

(duration) coma yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests etc.

(Signed) A. Krupp, M. D.

7-12, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial: 7/10 1927

20 UNDERTAKER: Geo. E. Farley Sucsr

ADDRESS: 1 Eutaw & Fayette

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 23912

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23912

149

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 4-25

City of BALTIMORE: (No. 33 & Calvert St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Newton Menefee

(a) RESIDENCE NO. 328 N. Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Robert Menefee

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	70	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Wm George Menefee Sr.

11 BIRTHPLACE OF FATHER (City or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Lillard

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Hospital Record (Address)

15 Filed JUL 14 1927 19 HAMPSON JOHNS, R. Registrar

Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 12, 1927, that I last saw him alive on July 12, 1927, and that death occurred, on the date stated above, at 11:40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

Gall Stones

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 12, 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Gleason S. Hamrick, M. D.

19 (Address) Union Memorial Hospital 33 & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

Date of Burial 7-15 1927

20 UNDERTAKER E & J. Hasla

ADDRESS 115 E Mulberry

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Special 10-31—MAT—1500 lbs.

E 23913

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 W Fayette ST. 20-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Matilda Phelan

(a) RESIDENCE No. 1806 W Fayette ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H Phelan

6 DATE OF BIRTH (month, day, and year): March 4, 1844

7 AGE: Years 83 Months 4 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Nicholas Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Eliza Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: E M Dechenbury
(Address): 1806 W Fayette St

15 Filed JUL 14 1927 C. HAMPSON JONES, M.D. Registrar

Per Harris

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 12, 1927, that I last saw h alive on July 12, 1927, and that death occurred, on the date stated above at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(Apoplexy)

(duration) yrs. mos 2h ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

7/14, 1927 (Address) 108 N. Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 15 1927

20 UNDERTAKER: George J Smith — ADDRESS 153 L Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 23914 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23914

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence A. McCoy

(a) RESIDENCE NO. North-st. & Cedar Ave. ST., Balto. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug [redacted] 1860

7 AGE Years 66 Months 11 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Medcalf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Home for Incurables (Address) North-st. & Cedar Ave. Balto.

15 Filed JUL 14 1927 19 C. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927 to July 13, 1927.

that I last saw her alive on July 12, 1927.

and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Decompensation

(duration) 1 yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Martin F. Sloan M. D.

, 19 (Address) 413 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL July 15 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00

E 23915

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3714 Arabia Av. 17-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Runge

(a) RESIDENCE NO. 3714 Arabia Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S. if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Matilda Runge

6 DATE OF BIRTH (month, day, and year): January 11, 1859

7 AGE: Years 68 Months 6 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Stoff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Matilda Runge

(Address) 3714 Arabia Ave

15 Filed JUL 14 1927, 19

C. HAMPSON JONES, M. D. Registrar

By Eye

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 12 19 27 to July 13 19 27

that I last saw h alive on July 12 19 27

and that death occurred on the date stated above, at 3 7 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

* Arteriosclerosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death*

Did an operation precede death* Date of

Was there an autopsy*

What test confirmed diagnosis*

(Signed) Chas Dunn M. D.

7 13 19 27 (Address) 4 206 Hopkins Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

Date of Burial JUL 16 19 27

20 UNDERTAKER Geo W Little

ADDRESS 1000 EDMONDSON AVE

JUL 14 1927

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23916

CERTIFICATE OF DEATH.

90 E 23916

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 805 N. Luzerne Ave St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Horadek

(a) RESIDENCE NO. 805 N. Luzerne Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Horadek

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Bohemia

PARENTS

10 NAME OF FATHER: Joseph Horadek

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Bohemia

14 Informant: Mary Lerec

(Address): 805 N. Luzerne Ave

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Per R.E. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15 1927 July 12 1927

that I last saw h.. alive on July 12 1927

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH was as follows: Mitral Valvular Stenosis

Lunatic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted: Mercy

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred A. Supplee M. D.

1927 (Address) 800 North Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial July 16 1927

20 UNDERTAKER: Isaac Eccleston Son ADDRESS 1906 Eastern Ave

DEATH is a matter of public record, so that it may be properly classified. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23917

REGISTERED NO. 117 E 23917

E 23917
1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Kares

(a) RESIDENCE NO. 909 S Port St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Kares

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 37 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): Street Car.

(c) Name of employer: United Railways Co.

9 BIRTHPLACE (city or town)
(State or country): Bohemia

PARENTS

10 NAME OF FATHER: Joseph Kares.

11 BIRTHPLACE OF FATHER (City or town)
(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Bohemia

14 Informant: Grace Kares
(Address): 909 S Port St

15 Filed ..., 19... Registrar
Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 14 – 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10 1927 to July 14 1927

that I last saw h... alive on July 14 1927

and that death occurred on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix
(Peritonitis)

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY
(Secondary) Toxemia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 7-10-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Fahnestock M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: July 18 1927

20 UNDERTAKER: Hunt Brookhart Son — ADDRESS: 1906 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Plack

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23918

CERTIFICATE OF DEATH.

29 E 23918

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2[illegible] Edmondson Av ST. 16-69 WARD)

2-FULL NAME Lily M. Plack

(a) RESIDENCE NO. 2[illegible] Edmondson Av ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Plack

6 DATE OF BIRTH (month, day, and year) July 6 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hugh M. Chandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ernest Plack

(Address) 2[illegible] Edmondson Ave

15 Filed JUL 14 1927 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to July 16 1927.

that I last saw her alive on July 14 1927,

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows

Pulmonary Thrombosis

(duration) yrs 7 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr. Edmondson M. D.

7/16, 1927 (Address) 5[illegible] Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 16 1927
20 UNDERTAKER E Schlosman Son	ADDRESS 1031 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23919 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1153 N. Fulton Ave WARD) 16-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Zimmerman

(a) RESIDENCE NO. 1153 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary S. Zimmerman

6 DATE OF BIRTH (month, day, and year): Apr 15 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philip Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Seifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Mary Zimmerman

(Address) 1153 N. Fulton ave

15 Filed JUL 14 1927 C. HAMPTON MOORE, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-12-27. 19

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to July 12, 1927, that I last saw h— alive on July 11, 1927, and that death occurred, on the date stated above at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Chas. C. Conner, M. D.

7/13, 1927 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL 7-15-27.

20 UNDERTAKER: M. Fahey & Sons — ADDRESS 1517 North Ave.

REGISTRATION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23920

CERTIFICATE OF DEATH.

129 E 23920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Carey ST. 19-26 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number)

2-FULL NAME Benjamin L. Bradley

(a) RESIDENCE NO. 526 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lila J. Bradley

6 DATE OF BIRTH (month, day, and year) June 4, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Conrad Hauper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Md.

PARENTS

10 NAME OF FATHER Jacob Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lila J. Bradley (Address) 526 N. Carey St.

15 Filed JUL 14 1927 19 Per H. HAMMERSLOUGH, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1927. to July 13 1927.

that I last saw him alive on July 13 1927.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension 6 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? P.S.

(Signed) Allen S. Bishop M. D.

7/13, 1927 (Address) 930 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Lorraine Cem DATE OF BURIAL July 15 1927.

20 UNDERTAKER Mc. Mrs. J. W. Teufel & Son ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23921 ✓ E 23921

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 S. Robinson St ST. 1-2 WARD)

2-FULL NAME Anthony Kluczynski

(a) RESIDENCE No. 2625 S. Robinson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonette Kluczynska

6 DATE OF BIRTH (month, day, and year) Dec 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0/14

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Prechocka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wife

(Address) 2625 S. Robinson

15 Filed JUL 14 1927, 19 C. HAMPSON JONES, M. D. Registrar Per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to July 13, 1927, that I last saw him alive on July 13, 1927, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs mos 3 ds

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & Symptoms

(Signed) John V. Kozlicki, M. D.

, 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	July 16 1927
20 UNDERTAKER	ADDRESS
George A. Weber	2205 Bank

IMPORTANT. Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23922

CERTIFICATE OF DEATH

E 23922

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HO[redacted] St., 19-27 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annie Miller

(a) RESIDENCE NO. 711 S. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1884

7 AGE: Years 42 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 169

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HO[redacted]

(Address [redacted] Records

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Registrar

Per K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to July 13, 1927

that I last saw h. alive on July 13, 1927

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia - left

arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Gross

(Signed) C. Arnold Bongs M. D.

19 (Address) [redacted] CITY H[redacted]

*State the Disease [redacted] Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial: July 16, 1927

20 UNDERTAKER: John J. Lawson & Son ADDRESS: 90 So. Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23923

CERTIFICATE OF DEATH.

74001

74 E 23923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 W. Lanvale St ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Schaeffer

(a) RESIDENCE No. 111 W. Lanvale St. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward K. Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Anna Schaeffer (Address) 111 W. Lanvale St.

15 Filed JUL 14 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from May 19 1927 to July 18 1927 that I last saw her alive on July 18 1927 and that death occurred, on the date stated above, at 4.080 m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegy

(duration) — yrs. 1 mos 25 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) Charles Lee, M. D.

7/19/1927 (Address) 111 W. Lanvale St. #1111

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL July 19, 1927

20 UNDERTAKER Henry W. Means Estate

ADDRESS 1625 Calvert St

IMPORTANT.—Physicians should state the cause of death so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-18-23—M&T—500 Bks.

Dr Tonkery
800 S. Ellwood Ave

E 23924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 23924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Broadway ST. 7-4 WARD)

2-FULL NAME Elizabeth Williams

(a) RESIDENCE NO. 607 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Williams

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Christine O'Connor

(Address) 607 S. Broadway

15 Filed JUL 14 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 7, to July 12, 19 7, that I last saw h[er] alive on July 12, 19 7, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows: Primary Cancer of Liver

Obstruction to Portal Circulation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal Abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Joseph Tonkery M. D.

, 19 (Address) 800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 15 1927

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS 1710 Fleet St.

TION is very important. See instructions on back of certificates.

...ENTIRELY in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23925 — 185 — E 23925

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 136 Belvedere Ave St. 7-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalene Bowers

(a) RESIDENCE NO. 136 Belvedere St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Bowers.

6 DATE OF BIRTH (month, day, and year): May 4, 1852

7 AGE — Years: 75 — Months: 7 — Days: 9

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Goldheimer

11 BIRTHPLACE OF FATHER (City or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Frank Himmel

(Address) 136 Belvedere Ave

15 Filed JUL 14 1927 19 — Per — Registrar

16 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 1927, to July 13 1927, that I last saw her alive on June 10 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gangrene

(duration) ... yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary): Fracture of Hip (Acc.)

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas J Neal M. D.

. 19 (Address) 1242 Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem.

Date of Burial: July 15 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23926 — REGISTERED NO. E 23926

118-002 1927 T 18 41

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Faulkland and Greene Sts. St., 20th Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Rost

(a) RESIDENCE NO. 2605 Dulany St. St. 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 15 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Rost

6 DATE OF BIRTH (month, day, and year) June 29 1861

7 AGE	Years	Months	Days	IF LESS than I day hrs. or min..
	65		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Rost

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Blunt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Emma Rost

(Address) 2600 Dulany St

15 Filed JUL 14 1927 19 HAMILTON JONES, M. D. Registrar

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1927, to July 13, 1927.

That I last saw h-- alive on July 13, 1927.

and that death occurred, on the date stated above, at 2:10 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/12/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles E. Gill M. D.

7/13, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial July 16, 1927

20 UNDERTAKER F B Wisehart ADDRESS 1850 W Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-13-25—MAT—500 Blks.

E 23927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1927 81 90 E 1846 E 23927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3418 S. Bentalou ST., 7th WARD)

2-FULL NAME Kunigunda Kittmann

(a) RESIDENCE NO. 341 S. Bentalou ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds. (If non-resident give city or town and State)

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John A. Kittmann

6 DATE OF BIRTH (month, day, and year): August 12, 1846

7 AGE: Years 81 | Months 3 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Schumacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Kittmann (Address) 341 S. Bentalou St.

15 Filed ..... 19 ..... Registrar R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 12, 1927, that I last saw h[er] alive on July 12 1927 and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Secondary to Senility.

(Duration) Abt 4 days.

CONTRIBUTORY (Secondary) Pulmonary Edema. (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert E. Lyle M. D.

7/17/27 (Address) 2151 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 15th 1927

20 UNDERTAKER: F.D. Heppert — ADDRESS: 1850 N. Charles St

JUL 14 1927 HAMILTON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

E 23928 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Lloyd Ave ST. 15-58 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Cameron

(a) RESIDENCE NO. 3901 Lloyd ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Serena Cameron

6 DATE OF BIRTH (month, day, and year) March 12, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hammersman

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R R.

(c) Name of employer 073

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John M. Cameron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) C. Charles Cameron 3907 Lloyd ave

15 Filed ..... 19 Per RH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1926 to July 13 1927

that I last saw him alive on July 12 1927

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Renal disease

Arteriosclerosis —

(duration) 1 yrs. 2 mos 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Bubert M. D.

, 19 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freeland, Balto Co. DATE OF BURIAL July 16 1927

20 UNDERTAKER E Leroy Stiffler ADDRESS 125 E. North Ave

C. HAMILTON JONES, M. D.

TION IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23929 Erma

CERTIFICATE OF DEATH.

11/7 E 23929

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 810 Edmondson Ave ST. 16-26 WARD)

2-FULL NAME Emma Johnson

(a) RESIDENCE. NO. 810 Edmondson ST. Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 8 mos 19 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Evelyn Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Evelyn Johnson (Address) 810 Edmondson ave

15 Filed JUL 15 1927 19 C. HAMPSON JONES, M. D. Registrar Per GHS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12 1927 to July 13 1927 that I last saw h alive on July 13 1927 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis Infantum
from Colitis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? (Have you the Symptoms)

What test confirmed diagnosis?

(Signed) Frank A. Foran M. D.

July 14 1927 (Address) 712 S. Wolfe Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 15 1927

20 UNDERTAKER: John A Trader — ADDRESS 1027 Wood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23930

CERTIFICATE OF DEATH

185 E 23930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 West Balto. St. 27 56 Ward)

2-FULL NAME Mrs. M. E. McCastline

(a) RESIDENCE NO. 52 E. Woodland Av. St. [illegible] Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jn. E. McCastline

6 DATE OF BIRTH (month, day, and year) March 4, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) [illegible] July 14 1927 Address 52 E. Woodland Av.

(State or country) M. D.

PARENTS

10 NAME OF FATHER Edward McCastline

11 BIRTHPLACE OF FATHER (city or town)

(State or country) M. D.

12 MAIDEN NAME OF MOTHER Eliz. Burnett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) M. D.

14 Informant Mrs. Jos. E. Castline

(Address) 52 E. Woodland Av

15 Filed JUL 15 1927 C. HAMPSON JONES M. C. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Fracture of neck of femur (duration) yrs. mos. 17 ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arund Ridge Date of Burial July 16 1927

20 UNDERTAKER Ehrenwerth & Son ADDRESS 5417 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 23931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 9 E 23931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Cecil ave St. 46 WARD)

2-FULL NAME Mary Gallagher

(a) RESIDENCE No. 2224 Cecil av St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced: (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Gallagher

6 DATE OF BIRTH (month, day, and year): Nov 1867

7 AGE: Years 59 | Months 8 | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Co Kildare Ireland

PARENTS

10 NAME OF FATHER: Patrick Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: R. J. Cashen

(Address): 210 Collins ave

15 Filed JUL 15 1927 C. HAMPSON JONES, M. D. Registrar

By EKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): 7/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/1 1927 to 7/14 1927.

that I last saw h[illegible] alive on 7/13 1927

and that death occurred, on the date stated above, at 6a m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of Brain

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Genaro Lyons, M. D.

7/15 1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 7/18 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1733 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

E 23932 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23932

CERTIFICATE OF DEATH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Age should be stated EXACTLY. PHYSICIANS should state

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 44 S. Bond St. 3-4 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda Rosenman

(a) RESIDENCE No. 44 S Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freda Rosenman

6 DATE OF BIRTH (month, day, and year) June

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Rosenman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Meyerowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Freda Rosenman

(Address) 44 S Bond St

15 Filed JUL 15 1927, 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from (at intervals), 19 27, to July 13 1927.

that I last saw h[illegible] alive on July 13 1927.

and that death occurred, on the date stated above, at 3:45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease (with Coronial attack)

Many

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis myocardial

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Francis A. Fricke, M. D.

July 15 1927 (Address) 927 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shaw Springs Run

DATE OF BURIAL 7-16 1927

20 UNDERTAKER D. Jack Lewis 1139

ADDRESS E. Baltimore St

JUL 15 1927

Spec.-7-17-26—A Co.—200 Bks.

E-23933

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23933

CERTIFICATE OF DEATH

REGISTERED NO. 89

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3720 Cottage Ave (24-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Bercovitz

(a) RESIDENCE NO. 3720 Cottage Ave St. ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose

6 DATE OF BIRTH (month, day, and year): Nov 11 1881

7 AGE — Years: 45 Months: 8 Days: 3 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Roumania

PARENTS

10 NAME OF FATHER: Abraham Bercovitz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Rumania

12 MAIDEN NAME OF MOTHER: N K.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rumania

14 Informant (Address): Rose Bercovitz 3720 Cottage ave

15 Filed JUL 15 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1927 2.20 PM

17 I HEREBY CERTIFY, That I attended deceased from August 1924 to July 14, 1927, that I last saw him alive on July 14, 1927, and that death occurred, on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) acute obliteration of Coronary arteries

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Samuel Silverstein M. D.

7/14, 1927 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

Date of Burial: 7/15 1927

20 UNDERTAKER: H. Adler Sons

ADDRESS 11 27 E Balto St

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23934

E 23934

E 23934

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: Alternate E Granby St. 3-5 Ward)

2-FULL NAME Andrew Kutches

(a) RESIDENCE NO. Alternate E Granby St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1872

7 AGE: Years: about 55 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mary Pracka

(Address) 309 Harford Ave

15 Filed JUL 15 1927 Registrar C. HAMPTON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ex Faustine

(Duration) yrs. mos. 1 ds.

July 13 1927 (Signed) G C Pates M. D. (Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: H. Wisdom Center — Date of Burial: July 15 1927

20 UNDERTAKER: Henry A. Wetzel — ADDRESS: 453 W. Lanvale

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 23935

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secour Hosp. St. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Glanville

(a) RESIDENCE No. 2529 W. Lanvale St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 16 1911

7 AGE: Years 16 Months 5 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Arthur C. Glanville

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Edna Vain

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ethel Quarles

(Address) 2529 W. Lanvale St

15 Filed JUL 15 1927, 19 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1927, to July 14, 1927, that I last saw her alive on July 14, 1927, and that death occurred, on the date stated above, at 5-10 p. m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) yrs. mos 35 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism 5 hours

(duration) mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ~~None~~

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hospl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 16 19 27

20 UNDERTAKER: Harry H. Wirtzke — ADDRESS: 538 W. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 23936 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23936

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 S Popeton ST. 71-24 WARD)

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHEL MAKSMUK OR MAKSYMUK

(a) RESIDENCE No. 313 S Popeton ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1884

7 AGE 43 Years – Months – Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labar

(c) Name of employer U.R.R.

9 BIRTHPLACE (city or town) (State or country) Russian

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russian

14 Informant J.Grebliauckas
(Address) 423 S Paca Street

15 Filed JUL 15 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13 1927. to July 13 1927.

that I last saw him alive on July 13 1927

and that death occurred, on the date stated above, at 11.30 P. M.

The CAUSE OF DEATH* was as follows:

Thermic Fever

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? working on street

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchmen, M. D.

, 19 (Address) 375 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rusian Indepedet — DATE OF BURIAL: July 16. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 23937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23937

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 1623 90

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Johnson

(a) RESIDENCE NO. 1360 N Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Chris Johnson

11 BIRTHPLACE OF FATHER (City or town) St. Louis

(State or country) Mo.

12 MAIDEN NAME OF MOTHER Marie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant BALTIMORE CITY HOSPITALS

(Address) Reando.

15 Filed JUL 15 1927 19 C. HAMPSON JONES, M. D. Registrar

Per A. Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 13, 1927, that I last saw h. alive on July 13, 1927, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis, chronic acute, arteriosclerosis, hypertension

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) multiple myelomas

(duration) yrs. mos 2 ds.

18 Where was disease contracted

If not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General + S. adv

(Signed) C. Holmes Vogel, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial July 15 1927

20 UNDERTAKER Carl. W. Chase & Son ADDRESS 1400 W. Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23938

E 23938

CERTIFICATE OF DEATH

REGISTERED NO. 15-51 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2320 Pennsa Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Jones Lee

(a) RESIDENCE NO. 2320 Penna Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Lee

6 DATE OF BIRTH (month, day, and year) Aug 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	25	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Bobby Jones

11 BIRTHPLACE OF FATHER (City or town) City

(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Myers

13 BIRTHPLACE OF MOTHER (City or town) City

(State or country)

14 Informant Daisy Jones

(Address) 232 Pennsa Ave.

Filed JUL 15 1927 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1927, to July 14, 1927, that I last saw h.. alive on July 12, 1927, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

0 1

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

7/14, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial July 16 1927

20 UNDERTAKER Clarence L. Griffith ADDRESS 1364 Mc...

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23939

CERTIFICATE OF DEATH.

129 E 23939

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2223 Madison St. 13-54 Ward)

2-FULL NAME Addie Anita Dorsey

(a) RESIDENCE NO. 2223 Madison Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Dorsey

6 DATE OF BIRTH (month, day, and year) May 26, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER William Cooper

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Adeline Johnson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant John Dorsey

(Address) 2223 Madison Ave.

15 Filed JUL 15 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1926, to July 13, 1927, that I last saw her alive on July 12, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis?

(Signed) E. William Tilley, M. D.

7/13, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery. Date of Burial July 16 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans St

Every item of information must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks

E 23940 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23940

CERTIFICATE OF DEATH. X 179

1-PLACE OF DEATH Volunteers of America Hospital 4-25 REGISTERED NO.

CITY OF BALTIMORE: (No. 418 W. Lexington ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle Winstead

(a) RESIDENCE NO. Stewartstown Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. D. Benton Winstead

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Dennis Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Lepley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. R. E. Oglesby (Address) 3402 Harford Road

15 Filed JUL 15 1927 C. HENRY LEE, M. D. Registrar H. Lass

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 13" 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1926, to July 13 1927, that I last saw her alive on July 13 1927, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Hilkerman, M. D.

7/13 1927 (Address) Walbert Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL 7/15/27

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 W. Baltimore St

IMPORTANT—This RECORD should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—300 Blks

E 23941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 23941

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 South Port St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Sitowska, (Known as Schaefer,)

(a) RESIDENCE NO. 824 South Port St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sitowski,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Stanislaus Sarziek,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Anna --- Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Wyprächt,

(Address) 824 S. Port Street

15 Filed ..... 19 ..... Registrar

JUL 15 1927 C. HAMPSON JONES, M. D.

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to July 13, 1927, that I last saw her alive on July 12, 1927, and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pilcher, M. D.

19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus.	July 16. 1927
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

IMPORTANT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23942

CERTIFICATE OF DEATH

46 E 23942

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605 Lancaster St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jaworska,

(a) RESIDENCE NO. 1605 Lancaster St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jaworski,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER John Napieralski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant

(Address) 1605 Lancaster Street

15 Filed ..... 19.. C. HAMPSON JONES M. D. Registrar

per

7 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 13, 1927,

that I last saw h[illegible] alive on July 13, 1927,

and that death occurred, on the date stated above, at 4.20 P- m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriosclerosis,

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Carcinoma Cervix.
(Secondary)

(duration) 1 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) Peter V. Zagrucki M. D.

. 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
ST. STANISLAUS CEMETERY	July 16 1927.
20 UNDERTAKER	**ADDRESS**
M J. Sadowski	705 S. Ann St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-26—A Co—200 Bks.

E 23943

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Hennessey

E 23943

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 Myrtle Ave St. 17 24 Ward)

2-FULL NAME Henry A. Erb

(a) RESIDENCE NO. 1308 Myrtle Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary

6 DATE OF BIRTH (month, day, and year): Jan 10-1857

7 AGE — Years: 70 — Months: 1 6 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 62

(c) Name of employer: Central Bank

9 BIRTHPLACE (city or town) _____ (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER: Christopher Erb

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Germany

12 MAIDEN NAME OF MOTHER: Catherine Jacobs

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Germany

14 Informant: Howard H. Erb (Address) 2912 Freemont

15 Filed..... 19..... Per _____ Deputy

JUL 15 1927 C. HAMPSON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Neilson M. D. (Coroner)

(Address) 2402 Eutaw Place

July 13 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 7/15 1927

20 UNDERTAKER: Harry W. Cook — ADDRESS 550 E North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.– 200 Bks.

E 23944

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23944

90

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 16-37

City of BALTIMORE (No. BALTIMORE CITY HOSP St. (If not in a hospital give its NAME instead of street and number.) [redacted] Ward)

2-FULL NAME Christopher Warwicks

(a) RESIDENCE NO. 12 E Ave a 17 E St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Warwicks

6 DATE OF BIRTH (month, day, and year) 5/13/1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asbestos worker

(b) General nature of industry business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Chas. Warwicks

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Sena Snider

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSP

(Address) [redacted] Rounds

15 Filed ..... 19 .....

Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/ 19 27.

17 I HEREBY CERTIFY, That I attended deceased from June 27. 1927. to July 14. 1927

that I last saw h.. alive on July 14 1927

and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis, chronic & acute arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Sub

(Signed) C. Sheldon Boyd, M. D.

19 (Address) BALTIMORE CITY H[illegible]

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dickeyville Cemetery — Date of Burial 7/16 1927

20 UNDERTAKER Wm Cook — ADDRESS 501 E Wash

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 15 1927 C. HAMPTON JONES

Spec.–7-17-26–A Co.–200 Bks.

E 23945

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23945

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland Gen. Hospital REGISTERED NO. 117 ✓ 6-45

City of BALTIMORE: (No. Baltimore and St., 8 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Ford

(a) RESIDENCE NO 1500 Clifton ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, (Married) Widowed or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Ford.

6 DATE OF BIRTH (month, day, and year) 1-20-1867

7 AGE Years 60 Months 5 Days 24 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fairmont W Va

(State or country)

PARENTS

10 NAME OF FATHER Wesley Lawson

11 BIRTHPLACE OF FATHER (City or town) Fairmont W Va

(State or country)

12 MAIDEN NAME OF MOTHER Margret Cox

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Marion State W Va

14 Informant (Address) Hospital Records

15 Filed JUL 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10th 1927 to July 14th 1927.

that I last saw her alive on July 14th 1927.

and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Chronic Nephritis

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation ✓ Bronchopneumonia

(15 months) (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-11-27.

Was there an autopsy? no

What test confirmed diagnosis? Operation ✓ Clinical Symptoms

(Signed) Jas A Armstrong M. D.

19 (Address) 1211 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont Somerset Co Date of Burial 7/16 1927

20 UNDERTAKER J. F. McCully ADDRESS ~~J. F. McC~~ 130 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23946

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23946

CERTIFICATE OF DEATH

57

1-PLACE OF DEATH — REGISTERED NO. 21-14

City of BALTIMORE (No. 1125 N Ostend St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Volkman

(a) RESIDENCE NO. 1125 N Ostend St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Volkman

6 DATE OF BIRTH (month, day and year): Aug 20 1860

7 AGE — Years: 66 Months: 10 Days: 14 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Volkman (Address) 1125 N Ostend St

15 Filed JUL 15 1927 C. HAMPSON JONES, M. D. Registrar

Prepared by A. W. Schaefer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): 7-14th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 19 27 to July 14, 1927, that I last saw ... alive on July 14, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Senile Debility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

7/14, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls (Violetsville) Date of Burial: 7-17 1927

20 UNDERTAKER: Jno Chas A G Rolde ADDRESS: 2377 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE RESERVED FOR BINDING

Spec.—12-9-25—A Co.—200 Bks.

E 23947

HEALTH DEPARTMENT—CITY OF BALTIMORE

75-00 E 23947

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE (No.) 734 Washington Blvd St. 21-24 Ward)

2-FULL NAME Dora Stolze

(a) RESIDENCE NO. 734 Washington Blvd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 years How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: F. | 4 Color or Race: W. | 5 Single, Married, Widowed or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Stolze

6 DATE OF BIRTH (month, day, and year): Apr 17. 1850

7 AGE: Years 77 | Months 3 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry business, or establishment in which employed (or employer): home duties

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Frederick Buckner

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Henry Stolze

(Address) 734 Washington Blvd

15 Filed ..... 19 .....

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10 19 27 to July 12 19 27

that I last saw her alive on July 12 19 27

and that death occurred on the date stated above, at 12.05 PM

The CAUSE OF DEATH* was as follows:

Hemi plegia

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm. H. Fruitnight M.D.

7-14-27 Address 682 Whitney Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial July 17 1927

20 UNDERTAKER: C. W Dill ADDRESS 3109 Fredk. Ave

Don't fail to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 23948

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 23948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital 25-72 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Leverna Cassady

(a) RESIDENCE NO. Morrell Park Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Cassady

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 60 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: David High

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country): " "

14 Informant: James Cassady

(Address): Morrell Park Md

15 Filed JUL 15 1927 16 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-30 1927 to 7-13 1927

that I last saw her alive on 7-13 1927

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho-Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical - X ray - etc.

(Signed) O. J. Knapp, M. D.

7-13, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial July 16 1927

20 UNDERTAKER: C. W. Dill ADDRESS 3109 Frederick Ave

Due should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 23949

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23949

CERTIFICATE OF DEATH

29-001

20465

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 713 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H Cooper

(a) RESIDENCE NO. 516 N. Bond St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7 1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	18	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Joshua Cooper

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Emma Quigley

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 15 1927 19 E. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 13, 1927, that I last saw h alive on July 13, 1927, and that death occurred, on the date stated above, at 7.50 P. M.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) C Carter Hudson, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bengies Md

Date of Burial July 16 19 27

20 UNDERTAKER Franklin W Seitz

ADDRESS 1794 W. 33 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 23950

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23950

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

City of BALTIMORE: (No. 4207 E Lombard St., 25th Ward)

REGISTERED NO. 1637

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Vasalli

(a) RESIDENCE NO. 4207 E Lombard St. Ward 25

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 18th 1924

7 AGE: Years 2 Months 9 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Giampatitto Vasalli

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Grande

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant (Mother) Mary Vasalli (Address) 4207 Lombard St.

15 Filed JUL 15 1927 C. HAMPSON JONES, M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: June 16 1929

20 UNDERTAKER: Kelly & Geiler ADDRESS 403 S. Howard St

Cut should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 23951

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23951

125

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 707 S. Potomac St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Everhardt.

(a) RESIDENCE NO. 707 S. Potomac St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 29 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Everhardt.

6 DATE OF BIRTH (month, day, and year) May 15th 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	66	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Aleva Everhardt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Katie. Werner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Katharine Everhardt

(Address)

15 Filed JUL 15 1927 C. HAMPSON JONES, M. D. Registrar

By A. A. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 1926 to July 12 1927

that I last saw h alive on 19

and that death occurred, on the date stated above, at 5 7/0 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Feb 1927

Was there an autopsy?

What test confirmed diagnosis? Operation.

(Signed) A. Ruppelsmeier M. D.

19 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. Date of Burial July 15 1927

20 UNDERTAKER Lilly & Geiler ADDRESS 403 S Hoff

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 23952 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 743 Edgewood St., 16-67 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Dearbach

(a) Residence No. 743 Edgewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If ~~married~~, widowed, ~~or divorced~~ (HUSBAND ~~of~~ to) WIFE of Charles Dearbach

6-DATE OF BIRTH (month, day and year) Apr 2/45

7-AGE. 82 yrs. 3 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework at home 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Austria

PARENTS.

10-NAME OF FATHER, Frank Weazel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Dorothy Setzer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant) Catherine Warfield

(Address) 743 Edgewood St

15- Filed JUL 15 1927 C. HAMILTON JONES, M. D., Registrar. By EKG

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 13/27

17- I HEREBY CERTIFY, That I attended deceased from Apr 4 1927 to July 13 1927

that I last saw h alive on July 12 1927

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Probable Carcinoma of liver

about 15 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice, asthenia, age

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual clinical

(Signed) H. C. Knipp M. D.

7/13, 1927 (Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Pleasant — DATE OF BURIAL. 7-16-27

20-UNDERTAKER. H C Brauning & Son — ADDRESS 617 N Howard St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23953

CERTIFICATE OF DEATH.

29-001 E 23953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Baltimore City Hospitals

City of BALTIMORE: (No.) (Ward)

2-FULL NAME Theodore Monroe

(a) RESIDENCE NO. 632 Josephine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colrd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Feb. 19th 1914

7 AGE: Years 13 Months 4 Days 15 — IF LESS than 1 day ....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER Wm Munroe

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER Rosie Warren

13 BIRTHPLACE OF MOTHER (city or town): Lexington Va

(State or country)

14 Informant: Rosie Munroe

(Address) 632 Josephine St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D.

Registrar

JUL 15 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 13th 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an (Investigation) (Inquest or autopsy (or both)) thereon and from the evidence obtained [illegible] find that said deceased came to [illegible] death on the day stated above.

(autopsy or inquiry.)

The CAUSE OF DEATH* was as follows: Acute Tetanus

Shot by Brother Arthur — in Right Thigh — Blank Cartridge

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Shot on July 4th 1927 went to Hosp. July 11/27

(Signed) Thos. B. Horton M. D.

(Coroner)

July 14th 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Cemtery Date of Burial 7/14 1927

20 UNDERTAKER: Walter B. Spriggs ADDRESS 1517 W. Baltimore St.

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 23954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 23954

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1946 West Fayette St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave A. Sharp

(a) RESIDENCE NO. 1946 West Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 8 mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Anna Anastasia Sharp

6 DATE OF BIRTH (month, day, and year) Dec 16 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	44	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 304

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Hearner

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John C Sharp

11 BIRTHPLACE OF FATHER (City or town) Caroline Co

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Herbst

13 BIRTHPLACE OF MOTHER (city or town) Edenville

(State or country) Ona

14 Informant Anna A. Sharp

(Address) 1946 West Fayette

15 Filed JUL 15 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25th 1927, to July 14th 1927

that I last saw him alive on July 14th 1927

and that death occurred, on the date stated above, at 5.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Nephritis

2 (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Thrombosis Femoral Vein

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward H. Herbst M. D.

2/5/27 (Address) 12 W Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 7/16 1927

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23955

CERTIFICATE OF DEATH

9400 ✓

E 23955

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1603 Jackson St. (Ward) 24-34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin David Fivored

(a) RESIDENCE NO. 1603 Jackson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Louise Fivored

6 DATE OF BIRTH (month, day, and year) Sept 21st 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	65	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Time Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer National Linam & Zinc Co

9 BIRTHPLACE (city or town) Lewistown

(State or country) Pa

PARENTS

10 NAME OF FATHER Keller Fivored

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Don't Know

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Don't Know

14 Informant Carrie L. Fivored

(Address) 1603 Jackson St

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15 1927 to July 13 1927

that I last saw h.. alive on July 13 1927

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows: Cardiac Asthenia

(duration) ..... yrs. ..... mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 1 yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Johnson M. D.

JN. 19 27 (Address) 1 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial 7/16/27

20 UNDERTAKER Geo Rebel & Son — ADDRESS 2503 Eutaw Pl

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23956

129 E 23956

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pitchard

(a) RESIDENCE NO. 310 S. Albemarle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Pitchard

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant [redacted]

(Address) [redacted]

15 Filed JUL 15 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/ 1927

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1927 to July 14, 1927

that I last saw him alive on July 14, 1927

and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Acute nephritis - interstitial

Hypertension

Arteriosclerosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) yrs. ? mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) C. Hulme Bond, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Date of Burial July 16 1927

20 UNDERTAKER Wendell Lilypool ADDRESS 3 W Lexington

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23957

CERTIFICATE OF DEATH

60-001 ✓

E 23957

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Jockel

(a) RESIDENCE NO. 2934 Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 6 mos. 8 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6th 1885

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
42	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Father

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John D. Jockel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelin Noack

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Orleans

14 Informant John D. Jockel

(Address) 2934 West Mosher

15 Filed JUL 15 1927 C. HAMPTON JONES, M. D. Registrar

Per R R

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-6, 1927, to 7-14, 1927

that I last saw h[illegible] alive on 7-14, 1927

and that death occurred, on the date stated above, at 6:10 A m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Thyroidectomy (duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Hospital

Did an operation precede death? Yes Date of 7-11-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathol.

(Signed) H. S. Anderson M. D.

. 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gr. Mt. Olivet Cem.

Date of Burial 7/17 1927

UNDERTAKER Violetville Md

ADDRESS 2606 Elmora

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 23958

REGISTERED NO. E 23958

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Travers (or Travis)

(a) RESIDENCE NO. 816 Pennington Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed JUL 15 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/1927.

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927 to July 14, 1927

that I last saw her alive on July 14, 1927

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sub.

(Signed) C. Stuart Bryce, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A&Co Date of Burial July 16 1927

20 UNDERTAKER John F. Dennis ADDRESS 415 Light St.

C. HAMPTON JONES, M. D.

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Graves.

Spec.–7-17-26—A Co.—200 Bks.

2nd 46 2

2nd E 23959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-001

E 23959

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecil Graves

(a) RESIDENCE NO. 16 Dr Harris Hill St. Ave Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 22 Months Days IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER Pett. Graves

11 BIRTHPLACE OF FATHER (City or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Nina Graves

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant Friends

(Address)

15 Filed ... 19... Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 3 1927 to July 14 1927

that I last saw him alive on July 14 1927

and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia & gastric hemorrhage.

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood examination

(Signed) E. Bowles Andrus M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlawn

Date of Burial: July 15 1927

20 UNDERTAKER: Sam H. Cassedy

ADDRESS: 1400 Mad...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

162

E 23960

CERTIFICATE OF DEATH.

REGISTERED NO. 23960

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bab Boy Bercovitz

(a) RESIDENCE NO. 119 N. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White (Jewish)

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
July 5, 1927

7 AGE — Years | Months | Days: 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaac Bercovitz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Roumania

12 MAIDEN NAME OF MOTHER Sarah Klear

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Roumania

14 Informant: Hosp Records
(Address)

15 Filed JUL 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-5, 1927, to 7-15, 1927, that I last saw h.e alive on 7-15, 1927, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the Bowels

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos 7 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) William Fehnel, M. D.

7/15, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holom Mt Carmel Date of Burial 7-15-1927

20 UNDERTAKER: D. Jack Levin ADDRESS: 1439 E. Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23961

CERTIFICATE OF DEATH.

X 74-006

E 23961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE (No. 810 N. Payson St., 16-22 Ward)

2-FULL NAME Zachariah Thomas Elliott

(a) RESIDENCE NO. 810 N. Payson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~yrs. 5 mos. ~dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Annie Elliott

6 DATE OF BIRTH (month, day, and year) September 13 - 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Calvert Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Abel Elliott

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lorana Evans

13 BIRTHPLACE OF MOTHER (city or town) Chesterfield Co.

(State or country) Md.

14 Informant Carrie Barnes

(Address) 810 N. Payson St.

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 14, 1927; that I last saw h.. alive on July 13, 1927, and that death occurred, on the date stated above at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ~yrs. ~mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) ~yrs. ~mos ~ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Leland, M. D.

7-14, 1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Groom's Island Calvert County Maryland — Date of Burial July 16 1927

20 UNDERTAKER Jos Forsters + Son — ADDRESS 173 S. Paca St.

JUL 15 1927

(Use typewriter or pen and black ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23962

CERTIFICATE OF DEATH

111-002

E 23962

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholomee Feeney

(a) RESIDENCE NO. 1125 N - Milton Ave St. Ward B+O

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife Cordelia

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 55 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Guard at Penitentiary

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): unknown

(State or country)

14 Informant: Mrs. Cordelia Feeney

(Address) 1125 N. Milton Ave.

15 Filed JUL 15 1927, 19 HAMILTON JONES M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 19

7/15/27 July 15-1927.

17 I HEREBY CERTIFY, That I attended deceased from 7/14/27, 19, to 7/15/27, 19,

that I last saw him alive on 7/15/27 AM, 19 27,

and that death occurred, on the date stated above, at 1.25 P.m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer (perforated) followed by general peritonitis of at least 24 hours duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) general peritonitis

about 24 hrs (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? yes Date of 7/14/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahrney M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Alphonsus Church Cem — Date of Burial: July 18, 19 27

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23963 ✓ 4 E 23963

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 26-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Kusala (Kozak)

(a) RESIDENCE NO. 11 S. 10th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 BALTIMORE CITY HOSPITALS Informant

(Address) [redacted] Records

15 Filed JUL 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/1927.

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927. to July 14, 1927.

that I last saw h[illegible] alive on July 14, 1927.

and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic meningitis.

(duration) yrs. mos. ? ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) C. Hubbard Lloyd, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Orthodox Cemetery Date of Burial July 16 1927

20 UNDERTAKER John M Weber ADDRESS 1800 E Fayette St

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23964

CERTIFICATE OF DEATH

154

E 23964

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 708-St.Paul-St. St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Laura Williams

(a) RESIDENCE NO. 708-St.Paul-St. St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 10 mos. 20 ds. How long in U. S. if of foreign birth? 81 yrs. 10 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Anson Williams

6 DATE OF BIRTH (month, day, and year) August-25-1845

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	81	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William S.Shoemaker

11 BIRTHPLACE OF FATHER (City or town) Phila.,

(State or country) Penna

12 MAIDEN NAME OF MOTHER Rebecca A.Grace

13 BIRTHPLACE OF MOTHER (city or town) Balto.Co.,

(State or country) Maryland

14 Informant Fredk.R.V.Williams,(son)

(Address) Cold Spring Lane-Hawthorne Rd.City

15 Filed JUL 15 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1927, to July 15 1927,

that I last saw h.. alive on July 15 1927,

and that death occurred, on the date stated above, at 10½ P m.

The CAUSE OF DEATH* was as follows:

Hepatic Zoster. (Chest - right shoulder, arm and chest)

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

July 15, 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial July-18-27

20 UNDERTAKER [illegible] — ADDRESS [illegible]

...ion of information ANS should state CAUSE ...ement of OCCUPATION is

...ATE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT tion should be carefully supplied. AGE should be stated EXACTLY. I OF DEATH in plain terms, so that it may be properly classified. Exac very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23965

CERTIFICATE OF DEATH

90 E 23965

REGISTERED NO.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1529-Park-Av. St., 14-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Kennard Seegar

(a) RESIDENCE NO. 1529-Park-Av. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State).

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 76 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (single)

6 DATE OF BIRTH (month, day, and year) About 1851

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
About 76		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Eastern Shore of

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Massay Seegar

11 BIRTHPLACE OF FATHER (City or town) EasternShore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Ann Hopper Emory

13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore

(State or country) Maryland

14 Informant Dr. J. King B.E.Seegar, (brother)

(Address) Roland Park, City.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927 to July 14 1927, that I last saw her alive on July 13, 1927, and that death occurred, on the date stated above, at 5.30a m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis (arteral)

(duration) About 2 mos. ds.

CONTRIBUTORY arteriosclerosis, chronic (Secondary)

myocarditis (duration) Several yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Horace Kretz, M. D.

19 (Address) 7138 Park ave Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — Date of Burial: July-16-'27

20 UNDERTAKER: STERLY & MOWEN COMPANY — ADDRESS: [illegible]

JUL 15 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23966

REGISTERED NO. 101-001 E 23966

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N Decker Lane WARD 7-11)

2-FULL NAME John C King

(a) RESIDENCE NO. 523 N Decker Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Cathrine King

6 DATE OF BIRTH (month, day, and year) Dec 2 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Elfinbine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Cathrine King (Address) 523 N Decker Lane

15 Filed JUL 15 1927, 19 C. HAMPTON JONES, M. D. Registrar R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927 to July 13, 1927

that I last saw him alive on July 18, 1927

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Emphysema (duration) yrs. mos. ds. (Chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Krause, M. D.

19 (Address) 1500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 16 1927
20 UNDERTAKER	ADDRESS
Martin W. Dipse	37 S. Amity St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23967

CERTIFICATE OF DEATH.

74001 E 23967

28-63

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 3808 Montgomery Ave. St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Dorethea Ohrmann

(a) Residence No. 3808 Montgomery Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married~~, ~~Widowed~~, ~~Divorced~~. (Write the word.)
female	white	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 26, 1845

7-AGE.	If LESS than 1 day,
82 yrs. 4 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Ohrmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Matilda Ohlenroth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Ernestine Ohrmann (sister)

(Address) 3808 Montgomery Ave.

15- Filed JUL 15 1927 19.. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 15, 1927

17- I HEREBY CERTIFY, That I attended deceased from July — 1926 to July — 1927

that I last saw her alive on July 14 — 1927.

and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Hypertension

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage —

Coma — (Duration) 2 wks — ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no —

What test confirmed diagnosis? usual

(Signed) Jacob Druckerman M. D.

19 (Address) 1256 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	July 18th. 19 27

20-UNDERTAKER Inglee & Sons Inc ADDRESS 414 Broadway.

Signing of certificate supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23968

CERTIFICATE OF DEATH.

74-001 E 23968

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1505 Jefferson ST. 6-9 (WARD)

2-FULL NAME. Wesley Annans

(a) RESIDENCE No. 1505 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	95.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Wesley Annans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Teresa Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant Matilda Annans

(Address) 1505 Jefferson St.

15 Filed JUL 15 1927 19 HAMPSON JONES, M. D. Registrar R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14-1927

17 I HEREBY CERTIFY, That I attended deceased from August —, 1917, to July 14-1927, that I last saw h[illegible] alive on July 9 -, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Slight cerebral hemorrhage (duration) — yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

7/15/1927 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — National Cemetery — DATE OF BURIAL July 18-27

20 UNDERTAKER Robert R. Wilkins — ADDRESS 1515 E. Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Nbs.

Butler

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23969 E 23969

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Rochambeau Apartments Charles & Franklin ST., 4-25 (WARD)

2-FULL NAME Victorine P. Butler

(a) RESIDENCE NO. Charles & Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Butler

6 DATE OF BIRTH (month, day, and year) July 4, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	0	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva Ehrhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jod. B. Galloway

(Address) Charles & Franklin Sts.

15 Filed JUL 16 1927 19 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1923 to July 14th, 1927.

that I last saw her alive on July 14th, 1927,

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar D. Perkins, M. D.

, 19 (Address) 1 West Franklin St. (Rochambeau)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans	7/16, 19 27

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23970

CERTIFICATE OF DEATH.

100 E 23970

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 N. Mount. ST.: 15-21 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Chase.

(Residence in Baltimore: No. 1400 N. Mount St.: 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 1 (Month) (Day), 1876 (Year)

7-AGE, 51 yrs. 0 mos. 13 ds.

If LESS than 1 day, ...hrs. or....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John Ford.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Susie Dent.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Madline Phillips.

(Address) 1400 N. Mount St.

15-

Filed JUL 16 1927, 191.. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH, July (Month) 14 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1927, to July 14 1927, that I saw her alive on July 12 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho pneumonia

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Ileo-colitis

(Duration) 0 yrs. 1 mos. 28 ds.

(Signed) John Ashbury M. D.

....., 191.. (Address) 1037 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, July 16, 1927

20-UNDERTAKER Thomas E. Kelson

ADDRESS 1317 Pleasant St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23971

CERTIFICATE OF DEATH.

E 23971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 711 E 30. (St.) 9-46 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henretta L. Hilseberg.

(a) RESIDENCE NO. 711 E 30th St (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John C. Hilseberg

6 DATE OF BIRTH (month, day, and year): Sept 12-1844

7 AGE: Years 83; Months 5; Days 3 27; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gettysburg Pa

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Henretta L. Collins 711 E 30th St

15 Filed JUL 16 1927 19 G.P.G. Registrar

C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 14, 1927, that I last saw her alive on July 14, 1927, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) E. L. Long M. D.

July 15 1927 (Address) 1701 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: July 16 1927.

20 UNDERTAKER: Wm E. Miller & Son — ADDRESS: 2334 E. Jefferson St

CAUTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23972

CERTIFICATE OF DEATH.

57 E 23972

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., 13-52 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fannie L. Blades

(a) RESIDENCE NO. 4015 - 51 - & Cedar Ave ST., Balto WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Blades

6 DATE OF BIRTH (month, day, and year) Feb. 14 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Wm. A. Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa-

12 MAIDEN NAME OF MOTHER Louisa A. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa-

14 Informant Home for Incurables

(Address) Hall - 51st & Cedar Ave Balto

15 Filed JUL 16 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927. to July 14, 1927.

that I last saw her alive on July 12, 1927.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Nephritis Interstitial

(duration) 6 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negro Coroner

(Signed) Martin F. Load M. D.

7-14-1927 (Address) 415 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL July 16, 27

20 UNDERTAKER Wm. J. Dickerson Sons ADDRESS North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23973

CERTIFICATE OF DEATH.

31 E 23973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 Cherry St. Curtis Bay St. 25-27 Ward)

2-FULL NAME Frank P. Kosar. Jr.

(a) RESIDENCE NO. 102 Cherry St. Curtis Bay. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXXXXXXX XXXXXXXXX Julia Kosar.

6 DATE OF BIRTH (month, day, and year) February 1, 1901.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist helper.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Kosar. Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Antonia Soustek.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia.

14 Informant Julia Kosar. (wife)

(Address) 102 Cherry St. Curtis Bay.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 16 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

7/15 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross cemetery Date of Burial: July 16 1927

20 UNDERTAKER: August Pasch ADDRESS: 2436 Ellsland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dr. Mohr

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23974

CERTIFICATE OF DEATH

3/ E 23974

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3406 Fait Ave St. (No-37) (Ward)

2-FULL NAME John W. Boblitz

(a) RESIDENCE No. 3406 Fait Ave St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Boblitz

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Shepherds Foundry

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Henry Boblitz

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Creamer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs. Minnie Boblitz
(Address) 3406 Fait ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to July 14, 1927, that I last saw h[illegible] alive on July 13, 1927, and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. 30 ds. (by knowledge)

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic Exam

(Signed) Ostmoth, M. D.

7/15, 1927 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: July 18 1927

20 UNDERTAKER: Henry Sander & Sons Inc. — ADDRESS: 1710 Fleet St

JUL 16 1927 HARRISON-JONES, INC.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23975

CERTIFICATE OF DEATH

90 E 23975

REGISTERED NO

(If death occurred in a hospital or institution give its NAME instead of street and number)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1604 Chilton St. ST., 9-46 WARD)

2-FULL NAME Agnes M. Rohde

(a) RESIDENCE NO. 1604 Chilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles L. Rohde

6 DATE OF BIRTH (month, day, and year) August 24, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Welsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Martin A. Rohde

(Address) 1509 E. 33rd St.

15 Filed JUL 16 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1920 to July 13, 1927.

that I last saw her alive on July 13, 1927.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH was as follows

Endocarditis, chronic
Myocarditis.

(duration) 7 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart Myocarditis

(Signed) [illegible] M. D.

July 16 1927 (Address) 301 S. Allen St.

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 16 1927

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS 1710 Fleet St.

PLEASE PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23976

CERTIFICATE OF DEATH

129 E 23976

REGISTERED NO.

13-59

1-PLACE OF DEATH

City of BALTIMORE: (No. Parkview Apts. D. Callow Ave. & Lake Drive St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Weiss

(a) RESIDENCE NO. Parkview Apts. D. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Korn Weiss

6 DATE OF BIRTH (month, day, and year) February 24, 1865.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager:-Box Manufactur-

(b) General nature of industry, business, or establishment in which employed (or employer) ers.

(c) Name of employer J. M. Raffel Co.

9 BIRTHPLACE (city or town) New York,

(State or country) N.Y.

PARENTS

10 NAME OF FATHER Aaron Weiss

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Johanna Cohen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Leah K. Weiss.

(Address) Parkview Apts.

15 Filed 19 Registrar

JUL 16 1927 HAYWOOD JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 21st 1915 to July 14 1927.

that I last saw h[illegible] alive on July 14 1927.

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis; Chronic nephritis

Symptoms (duration) 11 yrs. — mos. — ds.

CONTRIBUTORY Uraemia (Secondary)

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis F Hamburger M. D.

19 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Hebrew Cemetery	7/17/27
20 UNDERTAKER	ADDRESS
Harid Sondheim	115 W. Mt Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-12-26—A Co.—200 Bks.

E 23977

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 23977

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles [redacted] Barrett

(a) RESIDENCE NO. 1409 Mynster Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. Barrett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Samuels ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed ..... 19 ..... Registrar

JUL 16 1927 C. HAMILTON JONES, M. D.

Post G.G.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1927 to July 14, 1927.

that I last saw him alive on July 14, 1927

and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, acute
Arteriosclerosis
Hypertension

(duration) ..... yrs. mos 14 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. mos ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General + Syst

(Signed) C. Hamilton Jones M. D.

(Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. — 20 Date of Burial July 16 1927

21 UNDERTAKER Samuel Hensley — ADDRESS [redacted]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.R.S.-400 Blks.

E 23978 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23978

CERTIFICATE OF DEATH.

21-29 31

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1136 Cleveland St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thresia Louise Flock

(a) Residence No. 1136 Cleveland St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 7 mos. 23 ds. — How long in U. S., If of foreign birth? 7 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white.	Single

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 21, 1907.

7-AGE.	If LESS than 1 day,
19 yrs. 7 mos. 23 ds.	hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none except School-
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country), Balto., Md-

PARENTS.

10-NAME OF FATHER. Louis E. Flock

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Fort Myer, Va.

12-MAIDEN NAME OF MOTHER. Maried L. Jones

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Balto., Md-

11- (Informant). Louis E. Flock
(Address). 1136 Cleveland St.

15- Filed. 192. Registrar.

JUL 16 1927 C. HAMPSON JONES, M.D.

By —

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 14, 1927.

17- I HEREBY CERTIFY, That I attended deceased from July 9, 1927 to July 14, 1927
that I last saw her alive on July 13, 1927
and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) cardiac insufficency

(Duration) yrs. — mos. 2 1/2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual tests -

(Signed) George A Kupp M D
, 19 (Address) 3030 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	July 16, 1927
20-UNDERTAKER.	ADDRESS
Geo Lambdin & Son	5207 Lyndale

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 23979

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23979

CERTIFICATE OF DEATH

194

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 724 N. Spring St 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Cole

(a) RESIDENCE NO. 724 N. Spring St. Ward

(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Cole

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Stokes

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Rachael Cox

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Gertrude Johnson

(Address) 724 N. Spring Ave

15 Filed JUL 16 1927 C. HAMPTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 14, 1927, that I last saw h[illegible] alive on July 14, 1927, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency without mention

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Heart Exhaustion and Cardiac Asthma

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. C. Johnson M. D.

. 19 (Address) 1419 E Monument.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Ashbury Cemetery July 18 1927

20 UNDERTAKER — ADDRESS

A. Chris. H. Johnson 1611 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 23980 [illegible] Blks.

E 23980

2047-5-7

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paige Hudson

(a) RESIDENCE NO. 1711 E Lanvale St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
		6 wks	1d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country)

PARENTS

10 NAME OF FATHER John Hudson

11 BIRTHPLACE OF FATHER (City or town) Md -

(State or country)

12 MAIDEN NAME OF MOTHER Bernie Bradley

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 16 1927 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible] Assistant

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 - 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 15, 1927, that I last saw h[illegible] alive on July 15, 1927, and that death occurred, on the date stated above, at 2 35 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 4 1/2 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 1711 E. Lanvale

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	July 16 1927
20 UNDERTAKER Robt J Turner Sr	ADDRESS N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23981 — 88 E 23981

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 3017 Garrison Blvd. ST.; 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Cordish

(Residence in Baltimore: No. 3017 Garrison B'v'd, St.; ? yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 50 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired Mchnt.
(b) General nature of industry, business, or establishment in which employed (or employer) 0.4

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Myer Cordish

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Cordish

(Address) 2206 Mondawmin Ave.

15-

Filed ....., 191.... C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 15 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1926, to July 15 1927, that I saw h~~im~~ alive on July 15 1927, and that death occurred, on the date stated above, at 12 10 m.

The CAUSE OF DEATH* was as follows:

Subacut Bacterial Endocarditis.

..... (Duration) ..... yrs. 8 mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) B. Kadry M. D.

7-15, 1927 (Address) 2306 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodedale — DATE OF BURIAL, July 17, 1927

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 16 1927

Spec. 1-13-21 MAT 500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23982

E 23982

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1936 W Lexington ST. 70-27 WARD)

2-FULL NAME Ida Katzen

(a) RESIDENCE NO. 1936 W. Lexington ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Katzen

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63 ~~Y~~ ~~M~~ ~~D~~	2	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Shopsis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Farman

(Address)

15 Filed JUL 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17

I HEREBY CERTIFY, That I attended deceased from July 15 1927 to 19 ; that I last saw h alive on July 15 1927 ; and that death occurred, on the date stated above, at 7 AM PM.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Carpal Decompensation + Pulmonary Edema

(duration) 5 hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Raymond Peters, M. D.

, 19 (Address) 1908 W Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mash Rd DATE OF BURIAL July 17 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26-A Co.-200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23983

CERTIFICATE OF DEATH

117 E 23983

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes Woods

(a) RESIDENCE NO. 1524 Johns St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	widowed

5a If married, widowed, or divorced. ~~HUSBAND of~~ (or) WIFE of: widowed Francis T.

6 DATE OF BIRTH (month, day, and year): Dec. 16-1885

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	41	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Bentz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimor Md

12 MAIDEN NAME OF MOTHER: Morgaret Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Harry a. Bentz

(Address): ~~No~~ 1524 Johns

15 Filed ... 19 ... Registrar

JUL 16 1927 C. HAMILTON JONES, M. D.

For ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 16 27

17 I HEREBY CERTIFY, That I attended deceased from July 12 19 27 to July 16 19 27, that I last saw her alive on July 16 19 27, and that death occurred, on the date stated above, at 2 20 A. m.

The CAUSE OF DEATH* was as follows:

~~Appendicitis abscess~~ Ruptured appendix Peritonitis

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) yrs. mos. 7 da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? yes Date of 7/13/27

Was there an autopsy? no

What test confirmed diagnosis? Signs + symptoms

(Signed) H. Lamont Zahniser M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: 7/18 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E Wall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 23984 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23984

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 43 South Toppleton ST. 18-29 WARD)

2-FULL NAME Emma F. Treakle

(a) RESIDENCE No. 43 South Toppleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William Treakle

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
about	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Wms Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wms Va

12 MAIDEN NAME OF MOTHER Emma Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wms Va

14 Informant Archie C. Treakle

(Address) 47 S. Broadway

15 Filed JUL 16 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 4, 1926, to July 12, 1927, that I last saw h alive on July 12 1927 and that death occurred, on the date stated above, at 11:15 A m

The CAUSE OF DEATH* was as follows:

Arthritis Deformans, Myocarditis, Mitral Stenosis & Insufficiency

(duration) 3-4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) Nathan Hellman M. D.

, 19 (Address) 1304 E. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wms Virginia

DATE OF BURIAL 7/17 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23985 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23985

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 611 N Calhoun ST. 16-N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia C Stier

(a) RESIDENCE No. 611 N Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield Scott Stier

6 DATE OF BIRTH (month, day, and year) Nov 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George M & Boteler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown. D. C.

12 MAIDEN NAME OF MOTHER Ellen Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) J Edward Stier 611 N Calhouns

15 Filed JUL 16 1927 19 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17

I HEREBY CERTIFY, That I attended deceased from January (?) 1912 to July 15 1927.

that I last saw her alive on July 15 1927

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 15 yrs mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) C L Bugbee M. D.

7/15, 1927 (Address) 301 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL July 18 1927

20 UNDERTAKER Walter Schloman ADDRESS Alexandria Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26 A Co. 200 Bks.

E 23986

E 23986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wilton Miller

(a) RESIDENCE NO. 716 York St- St. Ward Hanover - Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-14-90

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist-

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Pa —

(State or country)

PARENTS

10 NAME OF FATHER George Miller

11 BIRTHPLACE OF FATHER (City or town) Pa -

(State or country)

12 MAIDEN NAME OF MOTHER Adelina Keller

13 BIRTHPLACE OF MOTHER (city or town) Pa -

(State or country)

14 Informant Records-

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 17 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12 1927 to July 16 1927

that I last saw him alive on July 16 1927

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis -

Ruptured Bladder (Urinary Extravasation) - Intraperitoneal

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 7/15/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Medical, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Penna Date of Burial 7/18 1927

20 UNDERTAKER William Cook ADDRESS 562 E. North

Spec.—1-10-21—M&T—1500 Bks.

E 23987 HEALTH DEPARTMENT—CITY OF BALTIMORE E 23987

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 E. 37th ST. 9-47 WARD)

2-FULL NAME Williams, John. Geary

(a) RESIDENCE No. 713 E. 37th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C.

6 DATE OF BIRTH (month, day, and year): Jul 20 1856

7 AGE: Years 71 Months 5 Days 24 (If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: machinist

(b) General nature of industry, business, or establishment in which employed (or employer): In Shop

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Waterford N.Y.

PARENTS

10 NAME OF FATHER: Lawrence Geary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Edw Geary 713 E 37th St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2. 1927. to July 14. 1927. that I last saw him alive on July 14. 1927. and that death occurred, on the date stated above at 5:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Tubulo nephritis

(duration) 5 yrs mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs mos ds.

18 Where was disease contracted? If not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C. L. Long M. D.

(Address) 2101 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Com — DATE OF BURIAL: 7/18 1927

20 UNDERTAKER: J. A. Moran — ADDRESS 3009 E Balto

JUL 17 1927 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

E 23988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 23988

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hospital St. 5-8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Yaffe

(a) RESIDENCE NO. 1010 E Balto St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jake

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 30 | Months — | Days — | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: David Dolreer

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Hannah Zaritsky

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Samuel

(Address) 1417 Eutaw ave

15 Filed ..... 19..... Registrar

JUL 17 1927

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 16 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-11, 19 27 to 7-16, 19 27,

that I last saw h.. alive on 7-16, 19 27,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab

(Signed) H Edmond Lewis, M. D.

7/16, 19 27 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd — Date of Burial 7/17, 19 27

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23989

CERTIFICATE OF DEATH.

194 E 23989

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Treadwell

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 4th 1840

7 AGE: Years 87 | Months 5 | Days 11 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Clark

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Grace Domsfield

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant (Address) Little Sisters of the Poor Preston & Valley St

15 Filed JUL 17 1927, 19 H. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 15th

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 ,

that I last saw h[illegible] alive on , 19 ,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Paraplegia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Albanese, M. D.

July 15 1927 (Address) 20 1153 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Charles Catonsville Date of Burial July 18 1927

20 UNDERTAKER: Rita Wiedefeld ADDRESS 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

2647373 E 23990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 23990

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hammer

(a) RESIDENCE NO. 509 S. Belnord St. Ave Ward 11th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Hammer

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Robert Beebe

11 BIRTHPLACE OF FATHER (City or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER ?/k

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 17 1927 19 By R.C. Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 — 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 29 19 27 to July 15 19 27.

that I last saw her alive on July 15 19 27

and that death occurred on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Syphilis

Carcinoma of Breast ?

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Charles Andrus, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: July 18 Oak Lawn

Date of Burial: July 18 19 27

20 UNDERTAKER: Peter Nicolaus & Son

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23991

CERTIFICATE OF DEATH.

129 E 23991

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1206 Cleveland St. 21-79 WARD)

2-FULL NAME Mary E. Becker

(a) RESIDENCE NO. 1206 Cleveland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Becker

6 DATE OF BIRTH (month, day, and year): Mar 21, 1861

7 AGE: Years 66, Months 3, Days 24, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Louis D. Kirchner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva E. Dreckenburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. A. Becker

(Address) 2553 Edmondson Ave

15 Filed JUL 17 1927 19 C. HAMPSON JONES, M.D. Registrar

Per EHS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15th, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 24th, 1927 to July 15th, 1927

that I last saw h[illegible] alive on July 14th, 1927

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination gross etc.

(Signed) D Harry Weibel M.D.

7/16 1927 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 18 1927

20 UNDERTAKER: Mrs. Mrs. John W. Teufel & Son — ADDRESS: 901 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 23992

HEALTH DEPARTMENT—CITY OF BALTIMORE

18-01 E 23992

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 2000-22 Ward)

2-FULL NAME Dora Ginsberg

(a) RESIDENCE NO. 2019 Eagle St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Ginsberg

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE — Years: 55 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Freiman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Lena Mosko

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Morris Freiman

(Address): 421 S Eutaw St

15 Filed JUL 17 1927 by E. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock following Operations for Intestinal Obstruction Acute Perit. Lenus — Had Pain how long Shock (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ileus (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

July 17, 1927 (Address) Weekly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mahlon Ct Date of Burial 7/19 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1419 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Jos Bindok

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23993

CERTIFICATE OF DEATH.

170 E 23993

1-PLACE OF DEATH

City of BALTIMORE: (No. 820 Hollins St. 18-76 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Bindok.

(a) RESIDENCE No. 820 Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Bindok

6 DATE OF BIRTH (month, day, and year): 1862.

7 AGE — Years: 65 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer): Gentlemens Tailoring

(c) Name of employer: John Dragon

9 BIRTHPLACE (city or town)

(State or country): Lithuania

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Lithuania

14 Informant: Edward Bindok (Son)

(Address): 820 Hollins St.

15 Filed JULY 1927 R K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide

Gun Shot of Right Side Head

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) July 16 1927 G. Gladis M. D.

(Coroner)

(Address) 1436 Bonay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudermilk — Date of Burial: 7/19 1927

20 UNDERTAKER: Chas B Zachamakas & Sons — ADDRESS: 637 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks. Anthony Jauks (or Youdegis)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23994

CERTIFICATE OF DEATH.

185 E 23994

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mer Hospital 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Jauks (also known as Youdegis)

(a) RESIDENCE NO. 672 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Youdegis

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 47 | Months — | Days — | IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER: Jos Youdegis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER: Jos Youdegis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant: Anthony Jauks (Same)

(Address) 672 W. Fayette St.

15 Filed JUL 17 1927 CHAMP. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc Fall from Window

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

July 16 (Signed) G. C. Schaider M. D.

27 (Address) 1437 W. 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial 7/18 1927

20 UNDERTAKER: Chas. B. Richardson & Son — ADDRESS 639 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

O'Hara.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23995

CERTIFICATE OF DEATH.

75-002

E 23995

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3534 Chestnut Ave ST.) 13-52 WARD

2-FULL NAME Catherine O'Hara

(a) RESIDENCE. No. 3534 Chestnut Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Michael O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss O'Hara
(Address) 3534 Chestnut Ave

15 Filed JUL 17 1927 Registrar HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20 1927 to July 16 1927

that I last saw h alive on July 15 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senile Dementia
Contusion.

(duration) yrs. 2 mos. + ds.

CONTRIBUTORY (Secondary) e

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) R. B. Edmund, M. D.

(Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nat'l Cathedral	July 19 1927
20 UNDERTAKER	ADDRESS
A. S. Marshall	3539 Fall Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 23996 — 129 E 23996

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6019 Maple Ave ST. Mt Wash 27-53 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Sterling

(a) RESIDENCE No. 6019 Maple Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 18. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61.		3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm M Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosalie Keyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Jos Graham

(Address) East Washington

15 Filed . . . . 19 . . . . Registrar

JUL 17 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 . 1927 . to July 15 . 1927 .

that I last saw her alive on July 15 . 1927 .

and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Epilepsy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) . yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. H Beeler M. D.

(Address) 1410 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 18 1927
20 UNDERTAKER	ADDRESS
A S Marshall	2539 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 23997

CERTIFICATE OF DEATH.

194 E 23997

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1437 Ward St. 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Malloch

(a) RESIDENCE NO. 1437 Ward St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Cold	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Malloch

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Henry Malloch

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Mills

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mary Williams (wife)

(Address) 1437 Ward St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 14th, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat exhaustion

(duration) yrs. mos. 2 hrs ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

July 15th 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial July 17 1927

20 UNDERTAKER Samuel Easton ADDRESS 916 Ca ne.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 17 1927 C. HAMPTON JONES, M. D.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 23998 ✓ 120 E 23998

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Provident Hospital St., 16 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Nelson

(a) RESIDENCE NO. 905 Pierce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 11 070

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER Richard Nelson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Rollens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Richard Nelson

(Address) 905 Pierce St

15 Filed , 19

Per

Registrar

JUL 17 1927 CHARLTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 16, 1927, that I last saw h[illegible] alive on July 15, 1927, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Uncertain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Johnston Gaines M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem July 17 1927

20 UNDERTAKER — ADDRESS

Daniel Easton Balto

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 23999

CERTIFICATE OF DEATH

E 23999

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. 2529 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Morgan

(a) RESIDENCE NO. 311 Scott St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1926

7 AGE Years 8 Months 9 Days 27, IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert R.E. Morgan

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Lillian Morgan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant R E Morgan

(Address) 311 Scott St

15 Filed JUL 17 1927 19 C. HAMILTON JONES, M.D. Registrar

Per RK

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16 1927 10.45 A.M. 19 to July 16 1927 1.45 A.M. 19

that I last saw h alive on July 19 27

and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Kirby M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Cathedral Date of Burial July 18 1927

20 UNDERTAKER George J. Smith ADDRESS Hollins

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALT

E 24000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No.) St. 25-7 Ward

2-FULL NAME John Garvey

(a) RESIDENCE NO. 3739 Morley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ds. (If non-resident g... how long in U. S., if of foreign bir... 15

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a ~~Unmarried~~, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 30 1881

7 AGE: Years 46 | Months | Days 1 | IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Md Steel & Electric Co

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER John Garvey

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Sister-in-law Mrs Thos Garvey

(Address) 3739 Morley Ave

15 Filed JUL 17 1927 H. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DE...

DATE OF DEATH (month, day, and year) 7-

I HEREBY CERTIFY, That I attended deceased from 7-14 1927, to 7-14, 1927.

That I last saw him alive on 7-14, 1927.

And that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

1. Volvulus of Small Intestine
2. Gangrene of Portion of Small Intestine.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ...

Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 7-14-

Was there an autopsy? no What test confirmed diagnosis? Clinical & Surgical

(Signed) C J Knapp

7-14, 1927 (Address) Saint Agnes Hos...

*State the Disease Causing Death, or in deaths fr... Causes, state (1) Means and Nature of Injury, and (2) Whe... dental, Suicidal, or Homicidal. (See reverse side for additio...

16 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem... Date of 7/...

17 UNDERTAKER John J Kelly & Sons ADD... 131...

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24001

CERTIFICATE OF DEATH.

194 E 24001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 Harford Road Nr Hamilton St., ~~Ward~~) 9-18

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E. Green

(a) RESIDENCE NO. 1910 Aisquith St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Green

6 DATE OF BIRTH (month, day, and year) ~~January~~ 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Edward Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Maggie Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Louise Green

(Address) 1910 Aisquith

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.

JUL 17 1927 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Thermic Fever- Taken sick at work

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

7/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial July 17 1927

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1225 Asht.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24002

CERTIFICATE OF DEATH.

1927 E 24002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 513 Cumberland St. St. 14 Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harriet Marie Collins

(Residence in Baltimore: No. 513 Cumberland St. St.; yrs. 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: 3 (Month) 19 (Day) 1926 (Year)

7-AGE: 1 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Arthur Collins

11-BIRTHPLACE OF FATHER. (State or Country): Illinois

12-MAIDEN NAME OF MOTHER: Eva Words

13-BIRTHPLACE OF MOTHER. (State or Country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Collins

(Address) 513 Cumberland St.

15-

Filed JUL 7 1927 19.....

C. HAMPSON JONES, M. D. Registrar.

Per K.C.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 15 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prostration by heat

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) no other cause

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

July 15, 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Haven De Grace — DATE OF BURIAL: 7-11-27

20-UNDERTAKER: Martin Fahey Sons — ADDRESS: 829 North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24003

CERTIFICATE OF DEATH

E 24003

Registered No. 13-54/29

1-PLACE OF DEATH

City of BALTIMORE: (No. 2542 Woodbrook St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Slunt

(a) Residence No. 2542 Woodbrook St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6a-If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Catherine Coffey

6-DATE OF BIRTH (month, day and year) July 22/49

7-AGE: ..... yrs. 11 mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Policeman
(b) General nature of Industry, business, or establishment in which employed (or employer): retired 061
(c) Name of employer: Balto City

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS:
10-NAME OF FATHER: don't know
11-BIRTHPLACE OF FATHER (city or town) (State or Country): don't know
12-MAIDEN NAME OF MOTHER: don't know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): don't know

14-
(Informant) Emma Slunt
(Address) 2452 Woodbrook Ave.

15-
Filed ..... 192 ..... C. HAMPTON JONES, Registrar

JUL 17 1927 Per ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 15/27

17- I HEREBY CERTIFY, That I attended deceased from June 15 1927 to July 15 1927
that I last saw h[illegible] alive on July 14 1927
and that death occurred, on the date stated above, at 12:30 a m.
The CAUSE OF DEATH* was as follows:
Enlarged prostate & nephritis

Duration: Several years

CONTRIBUTORY (Secondary): Stomach & intestinal Duration: ..... yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual tests

(Signed) H. E. Kyle M. D.
July 16, 1927 (Address) 2025 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (3) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 7-18-27

20-UNDERTAKER: Martin Fahey Sons — ADDRESS: 827 N. Howard Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24004 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 E 24004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Ha. Presby Hosp

CITY OF BALTIMORE: (No.) 1418 Eutaw Place (St.) 14-10 (WARD)

2-FULL NAME Robt S. Smith.

(a) RESIDENCE No. 1104 Virginia St Charleston W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 19 1869

7 AGE: Years 58 Months 5 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broker

(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Parkersburg W. Va.

PARENTS

10 NAME OF FATHER: Charles E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Mary P. Deboe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant: Charles E. Smith

(Address): Wash. D.C.

15 Filed JUL 17 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from dec'd July 9, 1927 to dec'd July 16 1927.

that I last saw him alive on July 16 1927.

and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Mediastinum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Edema of the Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X Ray & clinical test

(Signed) Thelma Neill Jr. M. D.

7-16 1927 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkersburg W. Va

DATE OF BURIAL: July 17 1927

20 UNDERTAKER: Geo. H. Cook

ADDRESS: 603 N. Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

(Alfred P. Mitchell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24005

CERTIFICATE OF DEATH.

90 E 24005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 546 N Mulberry St. 17-25 Ward

2-FULL NAME Alfred P. Mitchell

(a) RESIDENCE NO. 546 N. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year): July ? 1877

8 AGE: Years 50 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Excelsior Brick Co

10 BIRTHPLACE (city or town):

(State or country): Md.

PARENTS

11 NAME OF FATHER: Unknown

12 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

13 MAIDEN NAME OF MOTHER: Unknown

14 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Josephine Pierson

(Address): 546 W. Mulberry St

15 Filed JUL 17 1927 By [illegible] Registrar

C. HAMILTON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Mitral Stenosis

(duration) Chronic yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

July 16 27 (Signed) G. R. Brades M. D.

(Coroner)

(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial July 18 1927

20 UNDERTAKER: Charles H. Alexander ADDRESS 1700 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

Mrs. Minnie Knapp.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24006

CERTIFICATE OF DEATH

176 E 24006

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 116 Gilmor St. (Ward) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs Minnie Knapp.

(a) RESIDENCE NO. 1239 Darley Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen J Knapp.

6 DATE OF BIRTH (month, day, and year): 8-10-1882

7 AGE: Years 44 Months 11 Days 5 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Matthew Krieger

11 BIRTHPLACE OF FATHER (City or town) (State or country): ? Germany

12 MAIDEN NAME OF MOTHER: Eliz Donatz

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Mrs. Rebecca Knapp

15 Filed JUL 17 1927 19 C. HAMPTON JONES, M. D. Registrar

Del

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7-15-27

17 I HEREBY CERTIFY, That I attended deceased from 7-13-27 19 to 7-15-27 19, that I last saw h[illegible] alive on 7-15-27 19, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted? If not at place of death? Home

Did an operation precede death? Yes Date of 7/15/27 10 AM

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Tompkins, M. D.

, 19 (Address) 116 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: July 1927

20 UNDERTAKER: Geo. J. Ruth — ADDRESS: 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24007

CERTIFICATE OF DEATH

X 118-002

E 24007

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hosp St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Mitchell

(a) RESIDENCE NO. Aberdeen, Md. St. R.F.D. Ward Md. Gen. Hospital

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alonzo Mitchell

6 DATE OF BIRTH (month, day, and year) ~~July 17 1927~~ May 12 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	53	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER J. H. Anthony

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Sarah Allender

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant

(Address) Hosp Records.

15 Filed ..... 19 .....

JUL 17 1927

C. HAMPSON JONES, M. Registrar

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to July 17, 1927

that I last saw her alive on 7-17-27, 19....

and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of 7-16-27

Was there an autopsy? YES

What test confirmed diagnosis? Clinical

(Signed) Jno A Dempsey M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md Date of Burial July 20 1927

20 UNDERTAKER Hy. Fanning & Sons ADDRESS Aberdeen Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24008

CERTIFICATE OF DEATH

185

E 24008

1-PLACE OF DEATH Woman's Hosp. REGISTERED NO.

City of BALTIMORE: (No. Chas & Lexington St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Isabel Mordecai

(a) RESIDENCE NO. St. James apt. Charles & Centre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 14th 1841

7 AGE: Years 86 Months 5 Days 3 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Charleston

(State or country): S. C.

PARENTS

10 NAME OF FATHER Jno. M. C. Mordecai

11 BIRTHPLACE OF FATHER (City or town): Charleston

(State or country): S. C.

12 MAIDEN NAME OF MOTHER Isabel Lyons

13 BIRTHPLACE OF MOTHER (city or town): Charleston

(State or country): S. C.

14 Informant: Mrs. C. H. Hall

(Address) 1416 Eutaw St.

15 Filed ....., 19 ..... Registrar .....

JUL 17 1927 C. HAMPSON JONES, M. D.

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 July 17, 1927

I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to July 17, 1927, 19....., that I last saw her alive on July 17, 1927 19....., and that death occurred, on the date stated above, at 1:25 A m.

The CAUSE OF DEATH* was as follows:

Fracture of right hip 5-30-27 Slipped on the floor in the room

(duration) ..... yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam + X-Ray

(Signed) Wm W. Wilson, M. D.

7-17-1927 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ohev Shalom

Date of Burial: July 18 1927

20 UNDERTAKER: Henry W. Jenkins & Son

ADDRESS: Cleland & Colbert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 6-9-29 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24009

CERTIFICATE OF DEATH.

E 24009

REGISTERED NO. 31 2756

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4601 Pall Mall Ave ST.) (WARD)

2-FULL NAME John Wesley Plummer

(a) RESIDENCE. NO. 4601 Pall Mall Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Caroline Plummer

6 DATE OF BIRTH (month, day, and year) June 1, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38.	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Creamery Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Creamery.

(c) Name of employer Kendler Ice Cream Co.

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER J. Sidney Plummer

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Anderson

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Chas Messersmith (Address) Lakeland Balto

15 Filed JUL 18 1927 Registrar C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926. to July 15 1927.

that I last saw him alive on July 14 1927.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) George L Wray, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 18 1927
20 UNDERTAKER	ADDRESS
Nelson E. Stiles	234 Md. Ave Westport

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.-7-17-26—A Co.—200 Bks.

E 24010

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24010

CERTIFICATE OF DEATH

REGISTERED NO. 1945

1-PLACE OF DEATH

City of BALTIMORE: (No. 3229 Eastern Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wille.

(a) RESIDENCE NO. 3229 Eastern Ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of K. Caroline Wille.

6 DATE OF BIRTH (month, day, and year) March 13th 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	56	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Section Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Wille.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Wittkemper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant K. Caroline Wille.

(Address) 3229 Eastern Ave

15 Filed JUL 18 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9 1927 to July 14 1927

that I last saw h[illegible] alive on July 14 1927

and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos 3 ds.

18 Where was disease contracted —

if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Claudeau M. D.

July 16. 1927 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial July 18 1927

20 UNDERTAKER Lilly & Gillet ADDRESS 403 S. Mo[illegible] St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24011

CERTIFICATE OF DEATH.

117 ✓ E 24011

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 644 Smith ST. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margurite Brown

(a) RESIDENCE NO. 644 Smith St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female Ma

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Brown

6 DATE OF BIRTH (month, day, and year): June, 7th. 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Prince Geo. Co. Md.

PARENTS

10 NAME OF FATHER Henry Queen

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Prince Geo. Co. Md.

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Prince Geo. Co. Md.

14 Informant: Annie Brown

(Address) 904 N. Carey

15 Filed JUL 19 1927 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 15th. 1927

17 I HEREBY CERTIFY, That I attended deceased from From July 7th. '27 To. July 15th. 1927

that I last saw her alive on July 15th. '27, 19

and that death occurred, on the date stated above, at 12;25 p.m

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis

8

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Appendex

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial July 18 19 27

20 UNDERTAKER Samuel Stanley ADDRESS 578 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24012 | 129 | E 24012

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 7-27-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ward Klunk

(a) RESIDENCE NO. 5014 Denmore Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna K. Mrs Samuel Ward Klunk

6 DATE OF BIRTH (month, day, and year): Dec. 26, 1859

7 AGE: 67 Years 68 Months 6 Days 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 163

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Wash. (State or country) D.C.

PARENTS

10 NAME OF FATHER: Joseph Klunk

11 BIRTHPLACE OF FATHER (City or town): Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER: Harriet Kent

13 BIRTHPLACE OF MOTHER (city or town): Balto. (State or country) Md.

14 Informant: Samuel Ward Klunk (Address) same

15 Filed JUL 18 1927 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 July 16

17 I HEREBY CERTIFY, That I attended deceased from July 7, 19 27, to July 16, 19 27

that I last saw h.. alive on July 16, 19 27

and that death occurred, on the date stated above, at 12.06 P m.

The CAUSE OF DEATH* was as follows:

(a) Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Allen Wendy M. D.

7/16. 19 27 (Address) Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial July 19 1927

20 UNDERTAKER: Wm. L. Ecknor Sons — ADDRESS M. V. Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1100-001

X E 24013

REGISTERED NO. 347-71

E 24013

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles H McConnell.

(a) RESIDENCE NO. Towson 2nd St. Ward 205

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary P [illegible] McConnell

6 DATE OF BIRTH (month, day, and year): January 21 1869.

7 AGE: Years 57 Months 5 Days 26 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER: Thomas McConnell

11 BIRTHPLACE OF FATHER (City or town): Belfast (State or country) Ireland.

12 MAIDEN NAME OF MOTHER: Mary Ann Anderson

13 BIRTHPLACE OF MOTHER (city or town): Belfast (State or country) Ireland

14 Informant: Mrs. Chas. McConnell. (Address) Towson Maryland

15 Filed JUL 18 1927 19 C. HARRISON JONES, M. D. Registrar Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 17, 1927, that I last saw him alive on July 17, 1927, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Bilateral terminal Broncho Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Colitis

(duration) 2 yrs. ..... mos ..... ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of July 13 1927. Removal by Dr Finney

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. S. Anderson, M. D.

7/17, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

Date of Burial: 7/19 1927

20 UNDERTAKER: Mrs J Sickles & Son

ADDRESS: Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24014

CERTIFICATE OF DEATH.

88 E 24014

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4214 Groveland Ave. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Duering

(a) RESIDENCE NO. 4214 Groveland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie A. Duering.

6 DATE OF BIRTH (month, day, and year) May 27, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gregerson Bros. Co. Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Duering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ann Carlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Nellie Duering (Address) 4214 Groveland Ave.

15 Filed ..... 19 Per ..... Registrar

C. HAMPSON JONES, M. D.

JUL 18 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927, to July 16, 1927, that I last saw h[illegible] alive on July 15, 1927, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

acute Myocarditis

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall B Hurst, M. D.

July 19 27 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral Cem.	July 18 1927

20 UNDERTAKER Wm. Fletcher Sons ADDRESS Forest Park

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24015

CERTIFICATE OF DEATH.

31 E 24015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 N. Gay ST. 5-8 WARD)

2-FULL NAME Harry Peters

(a) RESIDENCE NO. 333 N. Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Henry Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Markley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City, Md.

14 Informant Herbert L Peters

(Address) 8 Strathmore Ave

15 Filed . . 19 C. HAMPSON JONES, M. D. Registrar

JUL 18 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 17, 1927.

that I last saw him alive on July 16, 1927

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S Di Stefano M. D.

July 17, 1927 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 7/17 1927

20 UNDERTAKER William Cook — ADDRESS 502 North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24016

CERTIFICATE OF DEATH.

E 24016

REGISTERED No. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 507 East 27th St. (Ward) 9-50

2-FULL NAME Harry Christian

(a) RESIDENCE NO. 507 East 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie A. Christian

6 DATE OF BIRTH (month, day, and year) Jan 22, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	5	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Christian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Meara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Elsie A Christian

(Address) 507 East 27th Street

JUL 18 1927

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12 1927 to July 14 1927.

that I last saw him alive on July 14 1927

and that death occurred, on the date stated above, at 8:25 P m

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Geo W. Murgatroyd M. D.

7/15 1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 18 1927

20 UNDERTAKER William Cook

ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24017 — 188-E 24017

REGISTERED NO. 16-36

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ____ Ward ____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Dilworth

(a) RESIDENCE NO. Colgate, Md St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 20-1900 Inquiry

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer General Electric Co

9 BIRTHPLACE (city or town) ____

(State or country) Phila, Pa

PARENTS

10 NAME OF FATHER George C. Dilworth

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Bortner

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Pa

14 Informant Geo. C. Dilworth
(Address) Glen Rock, Pa.

15 Filed JUL 18 1927 16 ____ Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ____ (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Fracture Pelvis, Automobile accident at Bank & Ann sts.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jos. J. Peter M. D.
(Coroner)

7/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery Date of Burial 7/18 1927

20 UNDERTAKER William Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24018

CERTIFICATE OF DEATH.

E 24018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1623 N. Patterson Park ST., WARD)

2-FULL NAME Myrtle Virginia Gunter

(a) RESIDENCE NO. 1623 N. Patterson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Herman Gunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Herman H. Gunter

(Address) 1623 N. Patterson Park

15 Filed JUL 18 1927 19 C. HARRISON JONES, M. D. Registrar

Per SAS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 16 1927

that I last saw h alive on July 16 1927

and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Acute Emphysema

Pathological Total

Malnutrition (duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Dilatation

(Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of pre-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Forrest Symonds M. D.

19 (Address) 1000 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Country

DATE OF BURIAL July 18 1927

20 UNDERTAKER Herman Cook

ADDRESS 502 E Nor

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24019

CERTIFICATE OF DEATH

100-001 E 24019

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS 13-54 REGISTERED NO.

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pistel

(a) RESIDENCE NO. 2320 Callow Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan 1st 1882

7 AGE: Years 45 Months 6 Days 13 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Jay Court 009

(c) Name of employer: City

9 BIRTHPLACE (city or town) .....

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Pistel

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Geyser

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Reside

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

JUL 18 1927 Per [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1927, to July 14, 1927

that I last saw h[redacted] alive on July 14, 1927

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Chronic Chronic arthritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gram and Sputum

(Signed) C. Hampson Jones, M. D.

19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

Date of Burial: 7/17/27

20 UNDERTAKER: Ulrich Herwig

ADDRESS 1716 Aliceanna St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24020

CERTIFICATE OF DEATH

E 24020

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Gr. Lombard & Green St. 8-16 Ward)

2-FULL NAME Harry Gruethlein

(a) RESIDENCE NO. 1626 N. Port St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 7-1919

7 AGE: Years 8 Months 4 Days 8 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Carl Gruethlein

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Doffenbaugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Hosp record

(Address)

15 Filed JUL 18 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927 to July 15, 1927, that I last saw h alive on July 15, 1927, and that death occurred, on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebellar tumor

(duration) intermittent yrs mos ds.

CONTRIBUTORY (Secondary) 9 months increased pressure (duration) yrs mos 1/2 ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? yes Date of July 15

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) E. A. Leplin, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. Date of Burial: July 18th 1927

20 UNDERTAKER: Leo G. Cook ADDRESS 1723 Patterson Park Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

Cor.—12-9-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24021 X/8 E 24021

REGISTERED NO. 24033

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil M. Quasney.

(a) RESIDENCE NO. Severn A. A. Co. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXX Anna Quasney.

6 DATE OF BIRTH (month, day, and year) January 26, 1880.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Alexander Quasney.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Pauline Walters.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Anna Quasney. (wife)

(Address) 42 Mason St. Masonville.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

JUL 18 1927 Pm

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the body due to gasoline igniting from an automobile. Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D. (Coroner)

7/17 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Severn Road A. A. Co. Md. July 15, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Swartz Cemetery Date of Burial 7-18 1927

20 UNDERTAKER Chas B. Hasle ADDRESS 115 E. Lee St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 24022

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24022

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Battery ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Stretch

(a) RESIDENCE NO. 1111 Battery ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer) self 086

(c) Name of employer Ditto

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arthur J. Stretch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary J. Rudolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary J. Stretch
(Address) 1111 Battery Ave

15 Filed . 19 Registrar

C. HAMPSON JONES, M. D.

JUL 18 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1926 to July 15, 1927.

that I last saw h[illegible] alive on July 15, 1927.

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

(Address) 6 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	July 18 1927
20 UNDERTAKER	ADDRESS
F. A. Kramer & Son	703 Hamburg

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24023 — 1947 — E 24023

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 500 Arlington Ave St., 27-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Shriver

(a) RESIDENCE NO. 500 Arlington Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Janie W. Shriver

6 DATE OF BIRTH (month, day, and year) Mar 4/1861

7 AGE	Years	Months	Days	IF LESS than 1 dny.....hrs. or.....min.
	66	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Alfred J. Shriver

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Hannah Wood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Janie W. Shriver

(Address) 500 ARlington Ave

15 Filed JUL 18 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

7/15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heat Prostration & Arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

(Signed) _____, M. D.

(Coroner)

7/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Towson Date of Burial July 18 1927

20 UNDERTAKER E. Le Roy Stiffler ADDRESS 125 Main St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24024

CERTIFICATE OF DEATH.

90 E 24024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 E. 30th. ST., 4-4th WARD)

2-FULL NAME Harry E. Norriss

(a) RESIDENCE NO. 919 E. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Norriss

6 DATE OF BIRTH (month, day, and year) May 7, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Delivery Man

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Eisenberg & Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Norriss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mrs. Harry E. Norriss Jr.

(Address) 919 E. 30th. Street

15 Filed JUL 18 1927 16 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1926 to July 15th, 1927.

that I last saw h~ alive on July 14th, 1927

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypocardatis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. W. Mahzoray M III M.D.

7/16/1927 (Address) 401 E 25th 380

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	7/18 19 27

20 UNDERTAKER Henry U. Dears & Son ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24025

CERTIFICATE OF DEATH.

74-001

E 24025

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 909 University Parkway (Street) 13 (WARD) 5392

2-FULL NAME Damicella M Byerly 13/6 WARD

(a) RESIDENCE No. 909 University Parkway. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Byerly

6 DATE OF BIRTH (month, day, and year): Mch 25 1842

7 AGE: Years 85 Months 3 Days 21 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Wellsain Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ivor Va

12 MAIDEN NAME OF MOTHER: Ann Talifferro

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant (Address): John L. Byerly Jr. Rodgers Forge Towson Md.

15 Filed JUL 18 1927 19 C. HAMPSON JONES, M. D. Registrar Per E H G

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15-27

17 I HEREBY CERTIFY, That I attended deceased from July 9 1927 to July 15 1927.

that I last saw her alive on July 14 1927.

and that death occurred, on the date stated above, at 7 a m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): General Arteriosclerosis (duration) many years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

July 16 1927 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 18 1927

20 UNDERTAKER: Henry A. Jenkins & Son — ADDRESS: Mulberry & Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Andrew Frier)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24026

CERTIFICATE OF DEATH.

101-001

E 24026

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 Perry Ward) 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Frier

(a) RESIDENCE. No. 125 Perry Ward ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 26 1926

7 AGE: Years 1 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Andrew Frier

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER Georgia Frier July 27

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Georgia Frier
(Address): 125 Perry St

15 Filed JUL 18 1927 C. HAMPTON JONES, M. D. Registrar
Per GHG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 27

17 I HEREBY CERTIFY, That I attended deceased from July 4 1927, to July 18 1927, that I last saw h— alive on July 18 1927, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus typing

(Signed) [illegible] M. D.

(Address) 712 S Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct — DATE OF BURIAL: July 18 1927

20 UNDERTAKER: H. L. Brown's Son — ADDRESS: 616 W Fayette

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24027

118-0

CERTIFICATE OF DEATH.

E 24027
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Levin

(a) RESIDENCE NO. 1622 E Baltimore St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie

6 DATE OF BIRTH (month, day, and year): Sept 28. 1892

7 AGE: 34 Years 35 | Months 8 9 | Days 19 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 003

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Levin

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Annie Samuels

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Annie Levin

(Address) 1622 E Balto St

15 Filed ..... 19 ..... C. HAMPSON JONES, JR. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 17, 1927, that I last saw h.m alive on July 17, 1927, and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 9, 1927

Was there an autopsy?

What test confirmed diagnosis? Clinical Diagnosis

(Signed) [illegible] M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Per — Date of Burial 7/18 1927

20 UNDERTAKER: Jos Levinson & Bro — ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 19 1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24028

CERTIFICATE OF DEATH.

E 24028

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1922 Gail ave ST. 9-46 WARD)

2-FULL NAME Laura Virginia Hollis

(a) RESIDENCE NO. 1922 Gail ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Hollis

6 DATE OF BIRTH (month, day, and year) Apr 4/ 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
79	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) ... Harford Co (State or country) Md.

PARENTS

10 NAME OF FATHER William Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Wimmer

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Cora M. Davis

(Address) 1922 Gail ave Balto Md.

15 Filed JUL 18 1927 19 C. HOLTON JONES, M.D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1926 to July 16 1927.

that I last saw her alive on July 16 1927.

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy -

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Clyde, M. D.

7/19/ 1927 (Address) 1180 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baker's Cem, Harford Co. Md. DATE OF BURIAL: Jul 19 1927

20 UNDERTAKER: J. B. Mitchell ADDRESS 800 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24029

CERTIFICATE OF DEATH

90 E 24029

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hosp. St. 816 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kugor Mueller

(a) RESIDENCE NO. 1710 N Collington Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Liberta Q Mueller

6 DATE OF BIRTH (month, day, and year): Apr. 24th 1854

7 AGE — Years: 73 Months: 3 Days: 21 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: August Mueller

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Earl Willhite

(Address): 1710 N. Collington Ave.

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

Per EKG

JUL 19 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-15-27

17 I HEREBY CERTIFY, That I attended deceased from 7-12- 19 27 to 7-15- 19 27

that I last saw h[illegible] alive on 7-15 19 27

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Car. Prostatitis

Chr Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema 12 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Fahrney M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: 7/19/1927

20 UNDERTAKER: E. J. Fanning

ADDRESS: Inc-1938 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co —200 Bks.

E 24030 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24030

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. 828 S. Bond St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Nace

(a) RESIDENCE NO. 828 S Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Nace

6 DATE OF BIRTH (month, day, and year) Oct. 2nd 1869

7 AGE: Years 57 Months 9 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Indnstry, business, or establishment in which employed (or employer): Common

(c) Name of employer City

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Geo W. Nace

11 BIRTHPLACE OF FATHER (city or town) Balto City

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Balto City

(State or country)

14 Informant Mrs. Cora Virginia Fisher

(Address) Washington & Eden

15 Filed....., 19.... JUL 18 1927 C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Tuberculosis Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart & Senility

(duration) yrs. mos. ds.

(Signed) James M Taylor M. D.

(Coroner)

7/16 1927 (Address) 702 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery Date of Burial 7/18/1927

20 UNDERTAKER: C. D. Timmins Nov 1938 E. Lafayette Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 24031

CERTIFICATE OF DEATH

E 24031

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. BALTIMORE CITY HOSPITALS Ward 24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meyer

(a) RESIDENCE NO. 122 S. Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	74	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Goderich Ont.
(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS
(Address) [redacted] Bowles

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

JUL 18 1927 Per E.H.Z.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16/1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1926 to July 16 1927
that I last saw her alive on July 15, 1927.
and that death occurred, on the date stated above, at 5:40 A. m.
The CAUSE OF DEATH* was as follows:

Chronic pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? General Symptoms

(Signed) C. Hampson Jones M. D.
19 (Address) BALTIMORE CITY HOSPITALS
[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	July 19 1927
20 UNDERTAKER	ADDRESS
Johannah Cooke	1004 Aisquith st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24032

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24032

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Myrtle Ave ST., 17-24 WARD)

2-FULL NAME Samuel Hazelton

(a) RESIDENCE No. 1138 Myrtle ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1843

7 AGE: Years 84 | Months 6 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centreville Md

PARENTS

10 NAME OF FATHER Chas Hazelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centre-ville Md

12 MAIDEN NAME OF MOTHER Cecelia Bantum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Centre-ville Md.

14 Informant Hattie Hooby

(Address) 1138 Myrtle ave

15 Filed JUL 18 1927 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6 1927 to July 16 1927 that I last saw h[illegible] alive on July 16 1927 and that death occurred, on the date stated above, at 3300 m.

The CAUSE OF DEATH* was as follows:

endocarditis & nephritis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

, 19 (Address) 169 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md.

DATE OF BURIAL 7 18 1927

20 UNDERTAKER [illegible] Fns. Dr. Skinner 1650 E. Madison

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 24033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24033

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 N. Milton ave. 6-16 Ward)

2-FULL NAME DORA GREEN

(a) RESIDENCE No. 1700 N. Milton ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Green

6 DATE OF BIRTH (month, day, and year) May 30 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa

(State or country)

PARENTS

10 NAME OF FATHER Jacob Weinstein

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Sophia Wyman

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14 Informant James Green

(Address) 1700 N milton ave

15 Filed ..... 19 ..... (Registrar)

JUL 18 1927 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH was as follows:

Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Carter M. D.

(Coroner)

(Address) 508 E North ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Date of Burial July 18 1927

20 UNDERTAKER Jack Leurs ADDRESS 1439 E Balto

C. HAMILTON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

Forwood.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24034 ✓ E 24034

90

CERTIFICATE OF DEATH

E 24034

1-PLACE OF DEATH Md General Hospital REGISTERED NO.

City of BALTIMORE: (No. 12-50 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles Forwood

(a) RESIDENCE NO. 2722 Guilford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Bertha A. Mrs. ~~Chas~~ Forwood

6 DATE OF BIRTH (month, day, and year) February 16-1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 053

(b) General nature of industry, business, or establishment in which employed (or employer) Pa. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Harford County, Md.

(State or country)

PARENTS

10 NAME OF FATHER W. S. Forwood

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford County, Md.

12 MAIDEN NAME OF MOTHER Rebecca Glean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford County, Md.

14 Informant Hospital record

(Address)

15 Filed JUL 16 1927 C. HAMPSON JONES, Registrar

By ..... Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1927

17 I HEREBY CERTIFY That I attended deceased from June 20 1927 to July 16 1927.

that I last saw h— alive on July 16 1927.

and that death occurred, on the date stated above at 11:50 a. m.

The CAUSE OF DEATH* was as follows

Cardiosclerotic disease

(duration yrs 6? mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema & Cardiac dilatation

(duration yrs. mos. 26 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. G. Thompson Jones, M. D.

, 19 (Address) The Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ignatius Cem Hickory Md Date of Burial 7/19 1927

20 UNDERTAKER Chas P. Maus & Son ADDRESS 118 W. Fayette Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24035

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24035

CERTIFICATE OF DEATH

179

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City or BALTIMORE: (No. Johns Hopkins Hospital St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Konieczny

(a) RESIDENCE NO. 614 ~~2333~~ S. Milton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) June 4/1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Stephen Konieczny

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Anna Dzmiela

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Father

(Address) 2433 Flat G.

15 Filed JUL 16 1927 C. HAMPSON JONES, M. D. Registrar

By H. Arnold

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally scalded- Fell into vessel of hoy water, at her home

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Hollins M. D.

(Coroner)

7/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. Date of Burial July 18 1927.

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St.

Spec.—1-10-21 M&T 1500 Blks.

E 24036 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Edmondson Ave. ST. 20-27 WARD)

REGISTERED NO ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Newton

(a) RESIDENCE NO. 1817 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
78 79	79	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 29

(c) Name of employer

9 BIRTHPLACE (city or town) Washington DC (State or country)

PARENTS

10 NAME OF FATHER Isaac Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Susan Pearston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Florence E Newton (Address) 1817 Edmondson

15 Filed JUL 18 1927 19.. By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 16, 1927, that I last saw h— alive on July 16, 1927, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows.

Broncho Pneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) ..... yrs. ..... mos 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lumpkin, M. D.

7/17 1927 (Address) 3402 Gallagher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 19 1927

20 UNDERTAKER George J Smith — ADDRESS 153 Hollins

INFORMATION SHOULD BE TYPEWRITTEN, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24037 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1047 W. Fayette St. (WARD) 18-76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Renninger.

(a) RESIDENCE NO. 1047 W. Fayette St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Turner

(b) General nature of Industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Renninger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ottilie Doppler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Renninger (Address) 1027 W. Fayette St.

15 Filed JUL 18 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 17 1927, that I last saw him alive on July 17 1927 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Helen F. Freeman M. D.

19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 20 1927

20 UNDERTAKER George J. Smith — ADDRESS 153 Collins

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24038 HEALTH DEPARTMENT—CITY OF BALTIMORE

4-E 24038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 N. Pal-Park ST. 7-12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Eyre Robinson

(a) RESIDENCE NO. 835 N Pal-Park ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie

6 DATE OF BIRTH (month, day, and year) Apr 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Capt. Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Major A Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Marconier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Marie Robinson

(Address) 835 N Pal-Park

15 Filed JUL 18 1927 C. HAMPSON JONES, Registrar

Per Walter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 7 1927

that I last saw h alive on July 6 1927

and that death occurred on the date stated above, at 3 A m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Aorta Cardiac Calcification

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of June 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Frederick Gray M.D.

July 8 1927 Address 1000 Brit Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL July 9 1927

20 UNDERTAKER M. Fox Cook ADDRESS 622 Ent Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24039

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24039

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 E 21st St., 9-50 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Carman

(a) RESIDENCE NO. 510 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word) Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H Carman

6 DATE OF BIRTH (month, day, and year) Jan 17th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	92	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gloucester (State or country) N.J.

PARENTS

10 NAME OF FATHER John T Byerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Croth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs John Lohr Link 510 E 21st St

15 Filed JUL 18 1927, 19 Per Records

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1910 to July 16, 1927, that I last saw h.. alive on July 16, 1927 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Senility

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hot weather

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Stanley Gosnell M.D.

, 19 (Address) 1100 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camp Chapel Cemetery Balto

DATE OF BURIAL July 19th 1927

20 UNDERTAKER Putnam & Lore

ADDRESS 1723 N Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24040 ✓ E 24040

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. General Hosp. (Street) 15th (WARD) 21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Wolfe

(a) RESIDENCE No. 1732 Greenbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of: Wilmot C Wolfe

6 DATE OF BIRTH (month, day, and year): ? 1902

7 AGE: Years 25 | Months | Days | IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ernest H. Luby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Maryland

12 MAIDEN NAME OF MOTHER: Clara Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs Wilmot C Wolfe

(Address): 1732 Greenbury St

15 Filed JUL 16 1927 Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5 1927 to July 16 1927 that I last saw her alive on July 16 1927 and that death occurred, on the date stated above, at 1.10 P. M.

The CAUSE OF DEATH* was as follows: Gangrenous Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 5, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) Paul Schenck, M. D.

, 19 (Address) West Balto. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: July 19 27

20 UNDERTAKER: John J Logan & Son

ADDRESS: 701 Pollitt St

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24041

10-of2 E 24041

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 15-68 WARD)

2-FULL NAME Charles Greenburg

(a) **RESIDENCE** No. 2024 Ruxton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Isadore Greenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isadore Greenburg. (Address) 2024 Ruxton ave

15 Filed JUL 18 1927 J. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-3, 1927, to 7-18, 1927, that I last saw him alive on 7-15-27, 19 and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Con.)

(duration) yrs mos 15 ds

CONTRIBUTORY (Secondary) Myocarditis 15 ds

Bron. Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Emergency Carried admitted Date of 7-15-27

Was there an autopsy? no

What test confirmed diagnosis? Lab. & Clinical

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodmere Cem. | DATE OF BURIAL 7/18 19 27

20 UNDERTAKER Jacob Frenz | ADDRESS 1639 E Baltimore St

Spec.—1-12-23—M&T—500 Bks.

Carnes

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24042

CERTIFICATE OF DEATH.

100-001

E 24042

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 N. Middle ST. Brooklyn 25-75 (WARD)

2-FULL NAME Mary E. Carnes

(a) RESIDENCE No. 9 N. Middle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): January 11 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm E. Carnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Margaret J. Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mother Margaret J. Carnes

(Address): 9 N. Middle St.

15 Filed JUL 18 1927 19 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927 to July 17, 1927

that I last saw her alive on July 17 1927

and that death occurred, on the date stated above, at 12 M p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell M. D.

(Address) 1644 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cemetery	July 17, 1927
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24043

CERTIFICATE OF DEATH.

31 E 24043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5301 Ferndale Ave ST. 28-64 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Straw

(a) RESIDENCE NO. 5301 Ferndale Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles E Straw

6 DATE OF BIRTH (month, day, and year) Dec 18/1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Patrick T. O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Bray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles E Straw (Address) 5301 Ferndale Ave

15 Filed ..... , 19 ..... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/16 , 19 27 . to 7/17 , 19 27.

that I last saw her alive on 7/16 , 19 27

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Bilateral)

(duration) 1 yrs. 6 mos 2 ds.

CONTRIBUTORY (Secondary) T.B. Laryngitis

(duration) yrs. 6 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hubert Burkey M. D.

, 19 (Address) 5150 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL July 20, 1927

20 UNDERTAKER Harry H Mumaw — ADDRESS Edgewood Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 24044

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 254 S. Robinson ST., 1 WARD)

2-FULL NAME Marie E. Williams

(a) RESIDENCE NO. 254 S. Robinson ST. 1 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roger Williams

6 DATE OF BIRTH (month, day, and year) Feb 27 1895

7 AGE — Years 31 — Months 4 — Days 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS
10 NAME OF FATHER Patrick Campbell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Ellen Lavery
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ellen Campbell
(Address) 254 S. Robinson St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 19 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927

17 I HEREBY CERTIFY, That I attended deceased from May 22 1927 to July 15 1927 that I last saw h[illegible] alive on July 13 1927 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Laboratory test

(Signed) Geo. Heller M. D.

19 (Address) 1937 Gough St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks Cem — DATE OF BURIAL 7/19/27

20 UNDERTAKER J. G. Doran — ADDRESS 3000 E. Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24045

CERTIFICATE OF DEATH.

129 E 24045

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1504 N. Bond ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Doud

(a) RESIDENCE NO. 1504 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Doud

6 DATE OF BIRTH (month, day, and year) Aug 15-1853

7 AGE Years 73 Months 11 5 Days 12 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Hugh Craven

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Doud

(Address) 1504 N. Bond St.

15 Filed JUL 18 1927, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 17 1927, that I last saw her alive on July 15, 1927 and that death occurred, on the date stated above, at 7 A m

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) E. Gill Hall, M. D.

7/17, 1927 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemty DATE OF BURIAL 7/19 1927

20 UNDERTAKER John. J. Moran ADDRESS 3[illegible] E. Balto St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1886003

E 24046

E-24046

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 3-4 Ward)

2-FULL NAME Catherine Green

(a) RESIDENCE NO. 1513 Eastern Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Sept 21/1916

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Green

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Palagia

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Russia

14 Informant Palagia Green

(Address) 1513 Eastern Ave

15 Filed JUL 19 1927, 19 C. HAMILTON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Both legs crushed
Run over by autotruck at 1513 Eastern Ave.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Weis M. D.

(Coroner)

7/15/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Indepedet — Date of Burial: July 19. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 24047

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24047

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3766 Rossville ST., 20th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredk J. Siegfried

(a) RESIDENCE NO. 3766 Rossville ST., 20th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 3rd 1882

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: William Lyerly Co

9 BIRTHPLACE (city or town)

(State or country): Maryland Md

PARENTS

10 NAME OF FATHER: John C. Siegfried

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: John C. Siegfried

(Address) 3766 Rossville Ave

15 Filed JUL 18 1927 19 C. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 1927 to July 17 1927

that I last saw h alive on July 17 1927

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans

1 (duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral insuff

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clo Phy Exam

(Signed) Fred T. Kyster M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: July 19 1927

20 UNDERTAKER: F. S. Hesselbrock

ADDRESS: 1550 N. Bond St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

John T. Stewart

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24048

CERTIFICATE OF DEATH

+ 31

E 24048

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 4-22 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Stewart

(a) RESIDENCE NO. Owings Mill, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Deserted.

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 51 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rosewood Training School

(b) General nature of industry, business, or establishment in which employed (or employer): attendant

(c) Name of employer: do

9 BIRTHPLACE (city or town): Cambridge Md

(State or country): do

PARENTS

10 NAME OF FATHER: W H Stewart

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unk

14 Informant: William Stewart

(Address): Cambridge Md.

15 Filed JUL 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/18 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/9, 1927 to 7/18, 1927 that I last saw him alive on 7/18, 1927 and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. X ray. Lab.

(Signed) H H Lowry, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md.

Date of Burial: 7/19/27

20 UNDERTAKER: S E Lecompte & Son

ADDRESS: Cambridge

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24049

CERTIFICATE OF DEATH

31 V

E 24049

REGISTERED NO.

3-5

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marie Bauersfeldt or Bauerefelder

(a) RESIDENCE NO. 132 S° Eden st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Oklahoma

PARENTS

10 NAME OF FATHER John Abbott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Hesentine Spencer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Oklahoma

14 Informant Hospital Records

(Address)

15 Filed JUL 18 1927 1549

16 G. HAMLIN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 3 19 27 to July 14 19 27

that I last saw her alive on July 14 19 27

and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Thelma Bryant M. D.

7-14-19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND. Department of Health. JUL 13 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

CERTIFICATE OF DEATH

E 24050 — REGISTERED NO. E 24050

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Sloman

(a) RESIDENCE NO. 2227 Cecil Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 5-7-27

7 AGE — Years: 0 — Months: 2 — Days: 8 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Alfred Sloman

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mildred Blythe

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): New York State

14 Informant: Hospital Record

(Address):

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 18 1927 1543

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7-15-27

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 19 27, to 7-15, 19 27, that I last saw him alive on 7-15, 19 27, and that death occurred, on the date stated above, at 11:A m.

The CAUSE OF DEATH* was as follows:

Otitis Media Empyema Empyema, Cerebral Abscess

(duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary): Leukemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) John Thompson M. D.

, 19 (Address)

*State the Primary Cause of Death. In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24051

CERTIFICATE OF DEATH

E 24051

REGISTERED NO. 16-001

1-PLACE OF DEATH Dr. White's Hospital

CITY OF BALTIMORE: (No.) 1029 Madison Avenue (St.) (14-59) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wilson

(a) RESIDENCE. NO. 569 Baker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXXX

6 DATE OF BIRTH (month, day, and year) July 15,1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: XXXXX

(b) General nature of indostry, business, or establishment in which employed (or employer): XXXXX

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): XXXXX Baltimore, Md.

PARENTS

10 NAME OF FATHER Herbert L. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant

(Address)

15 Filed ....., 19.... C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927 to July 17, 1927

that I last saw him alive on July 17, 1927

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectisis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) PREMATURE BIRTH Six months' Baby

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. White M. D.

. 19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

1534 RK

INFORMATION IN REGARD TO THE ABOVE ITEMS SHOULD BE STATED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24052

CERTIFICATE OF DEATH.

90 E 24052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 521 S Dallas St (Ward) 3-1

2-FULL NAME Antoni Jaskiewicz

(a) RESIDENCE No. 521 S Dallas St. (Usual place of abode) WARD

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Jaskiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kasia Gawronski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Jaskiewicz

(Address) 1708 Eastend av

15 Filed JUL 18 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 16, 1927,

that I last saw h— alive on July 15, 1927,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schenuit, M. D.

19 (Address) 1337 S Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 19 - 1927
20 UNDERTAKER	ADDRESS
J W Ozazewski	1930 Eastern

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Daniwski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24053

CERTIFICATE OF DEATH

34

E 24053

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 18 1927

1-PLACE OF DEATH

City of BALTIMORE: (No. Balt City Hospital, 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Daniwski

(a) RESIDENCE NO. 709 S. Montford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 17 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Decorator

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Daniwski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Trzycoska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Jak Daniwski

(Address) 709 Montgad

15 Filed 7-19, 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1927 to July 15, 1927

that I last saw h— alive on July 15, 1927

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Epidural Abscess 6th Dorsal Vertebra with Bilateral Paralysis both Lower extremities

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Unknown

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Blumgart, M. D.

19 (Address) Balt City Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial July 19 — 1927

20 UNDERTAKER F. W. Ozazewski ADDRESS 1930 Eastern Ave

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24054

CERTIFICATE OF DEATH.

E 24054

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1022 Whatcoat St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Green

(a) RESIDENCE NO. 1022 Whatcoat St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 24, 1924.

7 AGE — Years: 1 — Months: 1 — Days: 22. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER Mason Green

11 BIRTHPLACE OF FATHER (city or town):

(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Flora Jackson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Mason Green

(Address) 1022 Whatcoat

15 Filed ..... 19.. C. HAMPTON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping cough.

5 weeks (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

(Signed) C. H. Jones M. D. (Coroner)

June 16, 1927 (Address) 502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pookes Point Cem. Co. Md. Date of Burial 7/18/1927

20 UNDERTAKER: Chas. E. Alexander ADDRESS 1406 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L 6151 100

Spec.–7-17-26—A Co.—200 Bks.

2 0 47 24055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 E 24055
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No.) JOHNS HOPKINS HOSPITAL St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Catanese

(a) RESIDENCE NO. 924 N. Augusta St. Ward 25

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-4-27

7 AGE: Years — Months 5 — Days 14 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Pete Catanese

11 BIRTHPLACE OF FATHER (City or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Fortunato

13 BIRTHPLACE OF MOTHER (City or town) Italy
(State or country)

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 18 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 27, to July 18, 19 27, that I last saw h[illegible] alive on July 18, 19 27, and that death occurred, on the date stated above, at 10 35 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro intestinal indigestion

Pertussis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. R. Stevens Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: July 20 1927

20 UNDERTAKER: Frank Evaldson — ADDRESS: 1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24056

CERTIFICATE OF DEATH.

90 E 24056

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 E. Chase St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Hines

(a) RESIDENCE NO. 410 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Baylies Hines

6 DATE OF BIRTH (month, day, and year) Nov 5, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. S. Abell Co.

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Hines

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna.

12 MAIDEN NAME OF MOTHER Isabelle Weeks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Ella Baylies Hines

(Address) 410 E. Chase St.

15 Filed JUL 18 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 19

July 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1927, to July 17th 1927, that I last saw h alive on July 17th, 1927, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Endocarditis,

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death!

Did an operation precede death! Yes Date of ?

Was there an autopsy! No

What test confirmed diagnosis! ?

(Signed) Clovis Bueck, M. D.

7/18, 1927 (Address) 105 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Cemetery, July 20 1927

20 UNDERTAKER — ADDRESS

Chas. L. Black 742 W. North ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24057

CERTIFICATE OF DEATH

8-13 90

E 24057 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1620 E Biddle St., 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel A. Saffa

(a) RESIDENCE NO. 1620 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 26 - 1854

7 AGE — Years: 73 Months: 3 Days: 21 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Poultry & Eggs

(c) Name of employer: Schwyzer Bros

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Saffa

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Hall

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Edith Saffa

(Address) 1620 E Biddle St

15 Filed JUL 18 1927 19 C. LANE RICHARDSON, M.D. Registrar

By K M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 27, to July 13, 19 27,

that I last saw h alive on July 13, 19 27,

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

(Acute Nephritis)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY Chronic Nephritis

(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Fleming, M. D.

July 14, 19 27 (Address) 1834 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. Date of Burial: July 19 1927

20 UNDERTAKER: Wm. E. Black ADDRESS 1217 E. Broadway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24058 — REGISTERED NO. E 24058

1-PLACE OF DEATH

City of BALTIMORE: (No. 818 Woodyear 2d St. 11-23 Ward) 31

2-FULL NAME Alverta Kellem

(a) RESIDENCE NO. 818 Woodyear 2d St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1903

7 AGE: Years 24 — Months — — Days — — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town): Dont Know

(State or country)

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town): Dont Know

(State or country)

14 Informant: Mike Kellem

(Address) 818 woodyear st

15 Filed JUL 18 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Jones M. D.

(Coroner)

July 16, 1927 (Address) 1 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: July 18 1927

20 UNDERTAKER: Bennett Easton — ADDRESS 916

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24059 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 24059-

CERTIFICATE OF DEATH. 90 E 24059

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 149 N. Luzerne ST. 6-10 WARD)

2-FULL NAME Margaret E. Schroeder

(a) RESIDENCE NO. 149 N. Luzerne AVE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schroeder.

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Dockman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Deibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Schroeder (Address) 149 N. Luzerne AVE

15 Filed JUL 18 1927 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1927, to July 17, 1927, that I last saw her alive on July 16, 1927, and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Mitral Insufficiency)

(duration) yrs. 6 mos ds

CONTRIBUTORY (Secondary) Paralysis (Hemiplegia)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B Athey, M. D.

7/18. 1927 (Address) 2502 W. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL July 20, 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24060

E 24060

24060

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 Poplar Ave St.) (Ward) 27-42

2-FULL NAME Mary E. Armstrong

(a) RESIDENCE NO. 106 Poplar Ave St. Ward 27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 5 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Armstrong

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bridget Jennings

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: Emma M. L. Herbert

(Address) 102 Poplar Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

JUL 18 1927 P.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to July 16, 1927, that I last saw h.. alive on July 15, 1927, and that death occurred, on the date stated above, at 12:50 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) Gustave Rat, M. D.

July, 1927 (Address) Cooley's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 7/19 1927

20 UNDERTAKER: Mary M. Medford ADDRESS: 501-E 22nd St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

203901 **E 24061**

CERTIFICATE OF DEATH

24061 X 44 **E 24061**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Shanklin

(a) RESIDENCE NO. Fork - Md - St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
M or C	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/5-9

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (City or town) —

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Nichols -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 18 1927 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 14 1927 to July 18 1927

that I last saw him alive on July 18 1927

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia.

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death? Fork, Md.

Did an operation precede death? Yes. Date of June 20, '27.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hangl Chapel Cem Balto Co — Date of Burial July 20 1927

20 UNDERTAKER Clarence C. Arthur — ADDRESS Fork Md

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24062

CERTIFICATE OF DEATH.

102

E 24062

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE (No. Johns Hopkins Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dominic Mineri

(a) RESIDENCE NO. 300 S. Exeter St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? life yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) May 26/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Roco Mineri

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Talerico

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Balto., Md.

14 Informant Roco Mineri

(Address) 300 S. Exeter St

15 Filed JUL 19 1927 C. HAMILTON JONES, M. D. Registrar

R 140

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7/16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rickets-Malnutritution

Hydrothorax-right (Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

19 7/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial 7/19 1927

20 UNDERTAKER George J Ruth ADDRESS 1735 Hanford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24063 **E 24063**

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

Registered No.

City of BALTIMORE (No. 1335 N. Fremont Ave St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Rice

(a) Residence No. 1335 N. Fremont Ave St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 28 1927

7-AGE. ..... yrs. ..... mos. 16 ds.

If LESS than 1 day. .... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. child

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). 1335 N. Fremont
(State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Extra Rice

11-BIRTHPLACE OF FATHER (city or town). Lancaster
(State or Country). Va

12-MAIDEN NAME OF MOTHER. Annie Logan

13-BIRTHPLACE OF MOTHER (city or town). Lancaster
(State or Country). Va

14-

(Informant).

(Address).

15-

Filed ..... 192.....

C. HAMPTON JONES, M. D. Registrar.

JUL 19 1927 R.K.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12, 1927

17- I HEREBY CERTIFY That I attended deceased from June 27, 1927 to July 12, 1927.

That I last saw ~~him~~ dead ~~alive~~ on July 12, 1927.

and that death occurred on the date stated above, at 10 am

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam. Mother Mass.

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER.	ADDRESS

UNIVERSITY OF MARYLAND

UNIVERSITY OF MARYLAND

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-001

E 24064

REGISTERED NO. E 24064

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen Hosp Street 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie H Webster Jr

(a) RESIDENCE NO. 510 Maryland Ave Brooklyn Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Brooklyn Md

(State or country)

PARENTS

10 NAME OF FATHER Jessie H Webster Jr

11 BIRTHPLACE OF FATHER (city or town) Deals Island

(State or country)

12 MAIDEN NAME OF MOTHER Mildred A Hillyer

13 BIRTHPLACE OF MOTHER (city or town) Norfolk Va

(State or country)

14 Informant Mrs Jessie H Webster

(Address) 510 Maryland Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

JUL 19 1927 Per RK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to (Came) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemangioma (brain).

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Kennedy M. D.

(Coroner)

July 19 1927 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial July 19 1927

20 UNDERTAKER John F Denny ADDRESS 715 Lig St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24065

CERTIFICATE OF DEATH.

E 24065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Maryland Ave West ST.) (WARD) 25-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Spielman

(a) RESIDENCE NO. 19 Maryland Ave Westport WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Spielman

6 DATE OF BIRTH (month, day, and year): April 1, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: August Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmine Kirchof

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles J. Spielman (Address) 19 Md. Ave. Westport

15 Filed JUL 19 1927, 19 Registrar C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 19 25, to July 16, 19 27.

that I last saw he alive on July 15, 19 27.

and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 25 1927

Was there an autopsy? No

What test confirmed diagnosis? Cancer

(Signed) I. A. Simpson, M. D.

19 2 (Address) 907 London

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: July 19 1927

20 UNDERTAKER: Nelson E. Stiles

ADDRESS: 231 Md. Ave, Westport.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24066

CERTIFICATE OF DEATH.

E 24066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Parrish St. 16-22 WARD)

2-FULL NAME Sarah J Woolford

(a) RESIDENCE NO. 1123 Parrish St. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: James Woolford

6 DATE OF BIRTH (month, day, and year): ? ? 1864

7 AGE — Years: 63 — Months: ? — Days: ? — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cambridge Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Maggie Meredith
(Address) 1123 Parrish St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10 1927 to July 16 1927 that I last saw her alive on July 15 1927, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatoid Arthritis (duration) yrs. Under mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

Signed W. F. Howell, M. D.

7/19 1927 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lebanon City — DATE OF BURIAL: July 19, 1927

20 UNDERTAKER: Leonard Whalen Co — ADDRESS: Mt Royal ave

JUL 18 1927 J. LARKIN JONES, M. D.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24067

CERTIFICATE OF DEATH

32

E 24067

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE (No. 111 Mc Mechen St. 14-20 Ward)

2-FULL NAME Betty Dale Jackson

(a) RESIDENCE NO 111 Mc Mechen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1927

7 AGE: Years 4 Months 5 Days 24

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Chas F Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mildred Krum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Chas F Jackson

(Address) 111 [redacted]

15 Filed JUL 19 1927 19 K K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

T. S. meningitis

(duration) .....yrs. .....mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) S. T. Mennenga M. D.

(Coroner)

1927 (Address) 2807 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery | Date of Burial: July 19 1927

20 UNDERTAKER: Robt J Turner Sr | ADDRESS: 1727 Broadway

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 24068

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24068

CERTIFICATE OF DEATH.

89

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1831 N. Register St., 8 Ward) 8-17

2-FULL NAME Harry E. Garman

(a) RESIDENCE NO. 1831 N. Register St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Garman

6 DATE OF BIRTH (month, day, and year) Mar 6/1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Warren Garman

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Flora Cook

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Balto., Md.

14 Informant Jennie C. Garman

(Address) 1831 N. Register St.

15 Filed_____ 19____ By_____ Registrar

CHAMPION JONES, M. D.

L 19 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) History Angina Pectoris

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Bell M. D.
(Coroner)

7/18/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial July 21 1927

20 UNDERTAKER Robt J. Turner — ADDRESS 1729 E. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Dr Billups 2224 N. Howard

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24069

CERTIFICATE OF DEATH.

E 24069

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2406 Westwood Ave ST. 15-68 (WARD)

2-FULL NAME Thomas H Ford

(a) RESIDENCE NO. 2406 Westwood Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet A Ford

6 DATE OF BIRTH (month, day, and year) March 6. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mutual Life

9 BIRTHPLACE (city or town) (State or country) Balto Co, Md.

PARENTS

10 NAME OF FATHER Benjamin Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant Harriet A. Ford
(Address) 2406 Westwood Ave

15 Filed ..... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from ..... , 19 ... , to ..... , 19 ... ,

that I last saw h... alive on ..... , 19 ...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	July 21 1927
20 UNDERTAKER	ADDRESS
J. Cook	505 E Monument

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24070

CERTIFICATE OF DEATH.

182

E 24070

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Blue Pond, Cherry Hill Westport 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Jones, Jr.

(a) RESIDENCE NO. 1217 Durst Alley. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 27, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	18	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George W. Jones. Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Florence M. Newkirk.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant George W. Jones. Sr. (father)

(Address) 1217 Durst Alley.

15 Filed JUL 19 1927 GEO. W. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 17. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
While in bathing.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. W. Emmanuel M. D. (Coroner)

7/18 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Date of Burial July 20 1927

20 UNDERTAKER H. W. Cook ADDRESS 500 E. North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24071

CERTIFICATE OF DEATH.

11273

E 24071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 840 Calverton Road ST., (WARD) 46-67

2-FULL NAME John A. Martin

(a) RESIDENCE NO. 840 Calverton Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor D. Martin

6 DATE OF BIRTH (month, day, and year) Feb 14 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	46	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John A Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Eleanor D. Martin

(Address) 840 Calverton Rd

15 Filed JUL 19 1927 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to July 17, 1927, that I last saw h[illegible] alive on July 17, 1927, and that death occurred, on the date stated above, at 1145 P m

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue and pleura metastatic

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Tertiary Lues (Luetic)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Section Pathologist

(Signed) Joseph H. Pearlman M. D.

19 27 (Address) 1123 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 7/20 1927

20 UNDERTAKER William Cook — ADDRESS 501 N. Mt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

26 V 592 — E 24072 — 1-PLACE OF DEATH

122-002 — E 24072 — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Evans

(a) RESIDENCE NO. 522 N. Hoffman St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Man

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y. City

(State or country)

PARENTS

10 NAME OF FATHER Henry Evans

11 BIRTHPLACE OF FATHER (City or town) Porto Rico

(State or country)

12 MAIDEN NAME OF MOTHER Marquetta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 19 1927 19 C. HAMPSON JONES, M. D. Registrar

Par. R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 18, 1927, that I last saw h[illegible] alive on July 18, 1927, and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Oesophageal Varices — Cirrhosis of Liver

(duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary)

Cirrhosis of Liver (duration) 15 yrs. mos. da.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) E. Powles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Auburn Cem. — Date of Burial 7-20 1927

20 UNDERTAKER George T. Gelston — ADDRESS 1733 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 24073 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24073

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2261 Madison Ave ST., 13-59 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida H. Parker

(a) RESIDENCE NO. 2261 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. D. Parker

6 DATE OF BIRTH (month, day, and year) Sept 6-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Benj F Horn

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant C. D. Parker

(Address) 2261 Madison Ave

15 Filed JUL 19 1927 Per Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to July 18, 1927.

That I last saw her alive on July 18, 1927.

and that death occurred, on the date stated above, at 8, A, m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Jesse Hartzog, M. D.

July, 1927 (Address) 700 A N Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL July 20 1927

20 UNDERTAKER Chas E Franck ADDRESS 508 Madison Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24074

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24074

CERTIFICATE OF DEATH.

117

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 14-20 Ward)

2-FULL NAME Lucy Goulding

(a) RESIDENCE NO. 2035 Penna Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Goulding

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of indusiry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Lancaster Co., Va.

PARENTS

10 NAME OF FATHER Noah White

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Va

12 MAIDEN NAME OF MOTHER Ella Brougham

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Va

14 Informant John Goulding

(Address) 2035 Penna Ave

15 Filed JUL 19 1927 19__ C. HAMPSON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis — Adherent Omentum

(Operation) (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Gill M. D. (Coroner)

7/19/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Va Date of Burial July 1927

20 UNDERTAKER Edward Arnold ADDRESS 1718 Eutaw

(If death occurred in a hospital or institution, the NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

204 779

E 24075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24075

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eduard Handelsohn

(a) RESIDENCE NO. Fort Worth—Texas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Naples-Platter Co

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Texas

(State or country)

PARENTS

10 NAME OF FATHER E. Handelsohn

11 BIRTHPLACE OF FATHER (City or town) Texas

(State or country)

12 MAIDEN NAME OF MOTHER Addie Naples

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 19 1927 19 C. HAMPTON JONES, M. D. Registrar

Per R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to July 19, 1927, that I last saw h[illegible] alive on July 19, 1927, and that death occurred, on the date stated above, at 5-30 p. m.

The CAUSE OF DEATH* was as follows:

Addisons Disease (Tuberculosis of Adrenals.

Two weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Fort Worth, Texas

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings.

(Signed) E. Cowles Andrus M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherman Texas Date of Burial July 19 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

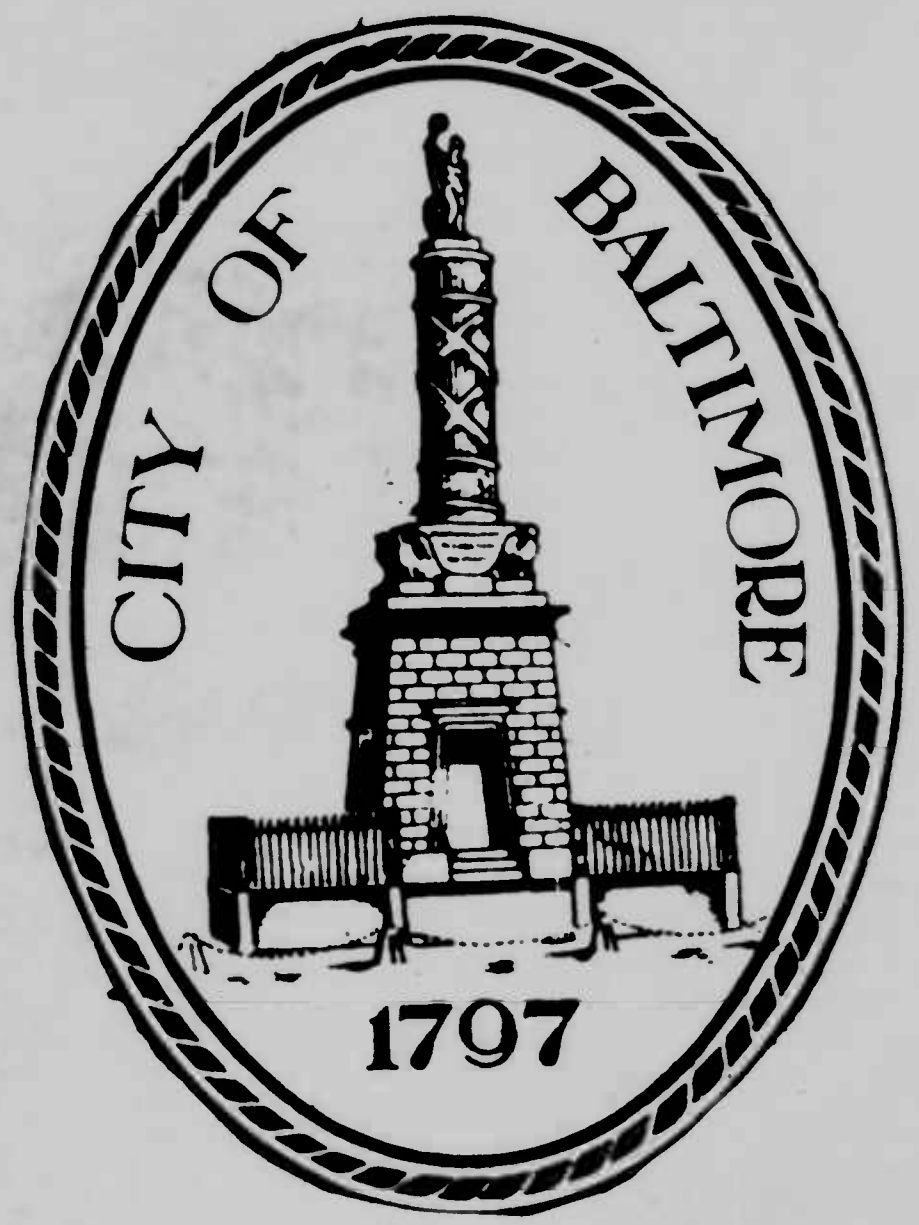
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 19th DAY OF April
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E 21051 April 10, 1927 AND
ENDING WITH #E 24075 July 19, 1927 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D MacFaul



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